Assembly Bill No. 2903

CHAPTER 857

An act to amend Sections 1618.5, 4382, 4999, 4999.4, 4999.6, and 4999.7 of the Business and Professions Code, Sections 43.98, 56.17, and 3296 of the Civil Code, Sections 10821 and 13408.5 of the Corporations Code, Sections 1322, 6253.4, 6254.5, 11552, 13975, 13975.2, 21661, 31696.1, and 37615.1 of the Government Code, Sections 1317.2a, 1317.6, 1341, 1341.1, 1341.2, 1341.3, 1341.6, 1341.7, 1342.3, 1342.5, 1343, 1346.5, 1347, 1357.16, 1363, 1367.25, 1367.695, 1368.02, 1368.2, 1371.4, 1373.95, 1374.30, 1374.32, 1380, 1380.1, 1383.15, 1391.5, 1396.6, 1397.5, 11758.47, 32121, 102910, 127580, and 128725 of, and to repeal Section 1398 of, the Health and Safety Code, to amend Sections 740, 742.407, 742.435, 791.02, 1068, 1068.1, 10123.35, 10123.68, 10140.1, 10169, 10169.2, 10169.3, 10169.5, 10196, 10270.98, 10704, 10733, 10734, 10810, 10820, 10856, 12693.36, 12693.365, 12693.37, and 12695.18 of the Insurance Code, to amend Section 4600.5 of the Labor Code, to amend Section 830.3 of the Penal Code, to amend Sections 5777, 9541, 14087.32, 14087.36, 14087.37, 14087.38, 14087.4, 14087.9705, 14088.19, 14089, 14089.4, 14139.13, 14251, 14308, 14456, 14457, 14459, 14460, 14482, and 14499.71 of the Welfare and Institutions Code, relating to health care coverage.

[Approved by Governor September 28, 2000. Filed with Secretary of State September 29, 2000.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2903, Committee on Health. Health care coverage: telephone medical advice services.

(1) Existing law provides for the regulation and licensing of health care service plans by the Department of Managed Care.

This bill would rename the Department of Managed Care as the Department of Managed Health Care. This bill would make various conforming changes.

(2) Existing law prohibits the department's director and designated staff members from holding interests, as specified, in a health care service plan during their association with the department.

This bill would specify that this provision does not prohibit these personnel, as well as any employee of the department, from obtaining as an enrollee or subscriber health care services from a health care service plan.

(3) Under existing law, a group health care service plan that provides coverage for outpatient prescription drug benefits is required to include coverage for contraceptive methods unless a

religious employer, as defined, requests a contract without this particular coverage. Existing law specifies that this provision, exempting coverage for contraceptive methods if requested by a religious employer, shall not be construed to deny an enrollee coverage and timely access to contraceptive methods.

This bill would delete this construction provision.

(4) Existing law provides, effective January 1, 2001, for the establishment of an Independent Medical Review System to review grievances involving a disputed health care service under a health care service plan and under a disability insurance contract. Under existing law, a disputed health care service is defined, for provisions pertaining to health care service plans, as excluding services provided by a specialized health care service plan unless the service is provided pursuant to a contract with a health care service plan, and for provisions pertaining to disability insurance contracts, this term is defined as excluding services provided by a group policy of vision-only or dental-only coverage unless the service is provided pursuant to a contract with a disability insurer.

This bill would specifically require that the health care service plan and the disability insurer cover hospital, medical, or surgical benefits in order for the services they provide through a contract with a specialized health care service plan or a group or individual policy of vision-only or dental-only coverage, respectively, to be included within the definition of a disputed health care service, subject to the Independent Medical Review System.

This bill additionally authorizes the Insurance Commissioner to contract with the Department of Managed Health Care to administer the Independent Medical Review System as it applies to disability insurers.

(5) This bill would make technical changes to various provisions pertaining to the regulation of health care service plans and disability insurers.

(6) Existing law provides for the registration of telephone medical advice services with the Telephone Medical Advice Services Bureau of the Department of Consumer Affairs, and prohibits, effective January 1, 2000, an in-state or out-of-state business entity from providing those services to a patient at a California address unless the person is registered. These provisions do not apply to healing arts professionals licensed under the Business and Professions Code who provide telephone medical advice that is incidental to their primary focus of their medical advice activities in their professional practice.

This bill instead would limit the application of these and related provisions to a business entity that employs, or contracts or subcontracts with, the full-time equivalent of 5 or more persons functioning as health care professionals, as defined, whose primary function is to provide telephone medical advice, as specified. This bill would revise various registration provisions and would authorize the

director of the department to exempt from fees certain telephone advice services that serve charity or medically indigent patients, as specified. This bill would make other related changes.

(7) Existing law requires health care service plans and certain disability insurers to provide or authorize a 2nd opinion by an appropriately qualified health professional if requested by an enrollee or insured, and defines ''appropriately qualified health care professional'' for these purposes to mean a primary care physician or a specialist who is acting within his or her scope of practice and who possesses a certain clinical background, as specified. A willful violation of the provisions governing health care service plans is a crime.

This bill would instead define ''appropriately qualified health care professional'' for these purposes to mean a primary care physician, specialist, or other licensed health care provider who meets these requirements. Because a willful violation of the bill's requirements with respect to a health care service plan would be a crime, this bill would impose a state-mandated local program by changing the definition of a crime.

(8) Chapter 525 of the Statutes of 1999, which created the Department of Managed Care, which this bill would rename the Department of Managed Health Care, amended various code sections relative to the assumption of responsibility from the Department of Corporations with regard to health care service plans. However, that chapter contained language deferring to other bills chaptered in 1999 in order to not chapter out those bills.

This bill would enact the changes made by various code sections contained in Chapter 525 of the Statutes of 1999 that did not become law due to that deferral provision.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1618.5 of the Business and Professions Code is amended to read:

1618.5. (a) The board shall provide to the Director of the Department of Managed Health Care a copy of any accusation filed with the Office of Administrative Hearings pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, when the accusation is filed, for a violation of this chapter relating to the quality of care of any dental provider of a health care service plan, as defined in Section 1345 of the Health

and Safety Code. There shall be no liability on the part of, and no cause of action shall arise against, the State of California, the Board of Dental Examiners, the Department of Managed Health Care, the director of that department, or any officer, agent, employee, consultant, or contractor of the state or the board or the department for the release of any false or unauthorized information pursuant to this section, unless the release is made with knowledge and malice.

(b) The board and its executive officer and staff shall maintain the confidentiality of any nonpublic reports provided by the Director of the Department of Managed Health Care pursuant to subdivision (i) of Section 1380 of the Health and Safety Code.

SEC. 2. Section 4382 of the Business and Professions Code is amended to read:

4382. The board may audit persons for compliance with the limits established in paragraph (3) of subdivision (a) of Section 4380 except that in the case of a facility or pharmacy that predominately serves members of a prepaid group practice health care service plan, those audits may be undertaken solely by the Department of Managed Health Care pursuant to its authority to audit those plans.

SEC. 2.1. Section 4999 of the Business and Professions Code is amended to read:

4999. (a) On and after January 1, 2000, no business entity that employs, or contracts or subcontracts, directly or indirectly, with, the full-time equivalent of five or more persons functioning as health care professionals, whose primary function is to provide telephone medical advice, shall engage in the business of providing telephone medical advice services to a patient at a California address unless the business is registered with the Telephone Medical Advice Services Bureau. The department may adopt emergency regulations further defining when a health care professional's primary function is providing telephone medical advice.

(b) Any business entity required to be registered under subdivision (a) that submits proof of accreditation by the American Accreditation Healthcare Commission, URAC, the National Committee for Quality Assurance, the National Quality Health Council, or the Joint Commission on Accreditation of Healthcare Organizations shall be deemed provisionally registered by the bureau until the earlier of the following:

(1) December 31, 2000.

(2) The granting or denial of an application for registration pursuant to subdivision (a).

(c) A medical group that operates in multiple locations in California shall not be required to register pursuant to this section if no more than five full-time equivalent persons at any one location perform telephone medical advice services and those persons limit the telephone medical advice services to patients being treated at that location.

SEC. 2.2. Section 4999.4 of the Business and Professions Code is amended to read:

4999.4. (a) Every registration issued a telephone medical advice service shall expire 24 months after the initial date of issuance.

(b) To renew an unexpired registration, the registrant shall, before the time at which the license registration would otherwise expire, apply for renewal on a form prescribed by the bureau, and pay the renewal fee authorized by Section 4999.5.

(c) A registration that is not renewed within three years following its expiration shall not be renewed, restored, or reinstated thereafter, and the delinquent registration shall be canceled immediately upon expiration of the three-year period. An expired registration may be renewed at any time within three years after its expiration upon filling of an application for renewal on a form prescribed by the bureau and the payment of all fees authorized by Section 4999.5.

SEC. 2.3. Section 4999.6 of the Business and Professions Code is amended to read:

4999.6. The department may adopt, amend, or repeal any rules and regulations that are reasonably necessary to carry out this chapter. A telephone medical advice services provider who provides telephone medical advice to a significant total number of charity or medically indigent patients may, at the discretion of the director, be exempt from the fee requirements imposed by this chapter. However, those providers shall comply with all other provisions of this chapter.

SEC. 2.4. Section 4999.7 of the Business and Professions Code is amended to read:

4999.7. (a) Nothing in this section shall limit, preclude, or otherwise interfere with the practices of other persons licensed or otherwise authorized to practice, under any other provision of this division, telephone medical advice services consistent with the laws governing their respective scopes of practice, or licensed under the Osteopathic Initiative Act or the Chiropractic Initiative Act and operating consistent with the laws governing their respective scopes of practice.

(b) For the purposes of this chapter, ‘‘telephone medical advice’’ means a telephonic communication between a patient and a health care professional, wherein the health care professional’s primary function is to provide to the patient a telephonic response to the patient’s questions regarding his or her or a family member’s medical care or treatment.

(c) For the purposes of this chapter, ‘‘health care professional’’ is a staff person described in Section 4999.2 who provides medical advice services and is appropriately licensed, certified, or registered as a registered nurse pursuant to Chapter 6 (commencing with Section 2700), a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000), a dentist pursuant to Chapter 4

(commencing with Section 1600), a dental hygienist pursuant to Section 1758 et seq., a psychologist pursuant to Chapter 6.6 (commencing with Section 2900), a marriage and family therapist pursuant to Chapter 13 (commencing with Section 4980), an optometrist pursuant to Chapter 7 (commencing with Section 3000), a chiropractor pursuant to the Chiropractic Initiative Act, or an osteopath pursuant to the Osteopathic Initiative Act, and who is operating consistent with the laws governing his or her respective scopes of practice in the state in which he or she provides telephone medical advice services.

SEC. 3. Section 43.98 of the Civil Code is amended to read:

43.98. (a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any consultant on account of any communication by that consultant to the Director of the Department of Managed Health Care or any other officer, employee, agent, contractor, or consultant of the Department of Managed Health Care, when that communication is for the purpose of determining whether health care services have been or are being arranged or provided in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and any regulation adopted thereunder and the consultant does all of the following:

(1) Acts without malice.

(2) Makes a reasonable effort to obtain the facts of the matter communicated.

(3) Acts with a reasonable belief that the communication is warranted by the facts actually known to the consultant after a reasonable effort to obtain the facts.

(4) Acts pursuant to a contract entered into on or after January 1, 1998, between the Commissioner of Corporations and a state licensing board or committee, including, but not limited to, the Medical Board of California, or pursuant to a contract entered into on or after January 1, 1998, with the Commissioner of Corporations pursuant to Section 1397.6 of the Health and Safety Code.

(5) Acts pursuant to a contract entered into on or after July 1, 2000, between the Director of the Department of Managed Health Care and a state licensing board or committee, including, but not limited to, the Medical Board of California, or pursuant to a contract entered into on or after July 1, 1999, with the Director of the Department of Managed Health Care pursuant to Section 1397.6 of the Health and Safety Code.

(b) The immunities afforded by this section shall not affect the availability of any other privilege or immunity which may be afforded under this part. Nothing in this section shall be construed to alter the laws regarding the confidentiality of medical records.

SEC. 4. Section 56.17 of the Civil Code is amended to read:

56.17. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by a health care service plan.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's ''written authorization,'' as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Health Care necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

SEC. 5. Section 3296 of the Civil Code is amended to read:

3296. (a) Whenever a judgment for punitive damages is entered against an insurer or health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, the plaintiff in the action shall, within 10 days of entry of judgment, provide all of the following to the Commissioner of the Department of Insurance or the Director of the Department of Managed Health Care, whichever commissioner has regulatory jurisdiction over the insurer or health care service plan:

(1) A copy of the judgment.

(2) A brief recitation of the facts of the case.

(3) Copies of relevant pleadings, as determined by the plaintiff.

(b) The willful failure to comply with this section may, at the discretion of the trial court, result in the imposition of sanctions against the plaintiff or his or her attorney.

(c) This section shall apply to all judgments entered on or after January 1, 1995.

(d) ''Insurer,'' for purposes of this section, means any person or entity transacting any of the classes of insurance described in Chapter 1 (commencing with Section 100) of Part 1 of Division 1 of the Insurance Code.

SEC. 6. Section 10821 of the Corporations Code is amended to read:

10821. Notwithstanding any other provision of this division, as to a health care service plan which is formed under or subject to Part 2 (commencing with Section 5110) or Part 3 (commencing with Section 7110) of this division, all references to the Attorney General contained in Part 2 or Part 3 of this division shall, in the case of health care service plans, be deemed to refer to the Director of the Department of Managed Health Care.

SEC. 7. Section 13408.5 of the Corporations Code is amended to read:

13408.5. No professional corporation may be formed so as to cause any violation of law, or any applicable rules and regulations, relating to fee splitting, kickbacks, or other similar practices by physicians and

surgeons or psychologists, including, but not limited to, Section 650 or subdivision (e) of Section 2960 of the Business and Professions Code. A violation of any such provisions shall be grounds for the suspension or revocation of the certificate of registration of the professional corporation. The Commissioner of Corporations or the Director of the Department of Managed Health Care may refer any suspected violation of such provisions to the governmental agency regulating the profession in which the corporation is, or proposes to be engaged.

SEC. 8. Section 1322 of the Government Code is amended to read:

1322. In addition to any other statutory provisions requiring confirmation by the Senate of officers appointed by the Governor, the appointments by the Governor of the following officers and the appointments by him or her to the listed boards and commissions are subject to confirmation by the Senate:

(1) California Horse Racing Board.
(2) Court Reporters Board of California.
(3) Chief, Division of Occupational Safety and Health.
(4) Chief, Division of Labor Standards Enforcement.
(5) Commissioner of Corporations.
(6) Contractors State License Board.
(7) Director of Fish and Game.
(8) State Director of Health Services.
(9) Chief Deputy, State Department of Health Services.
(10) Real Estate Commissioner.
(11) State Athletic Commissioner.
(12) State Board of Barbering and Cosmetology Examiners.
(13) State Librarian.
(14) Director of Social Services.
(15) Chief Deputy, State Department of Social Services.
(16) Director of Mental Health.
(17) Chief Deputy, State Department of Mental Health.
(18) Director of Developmental Services.
(19) Chief Deputy, State Department of Developmental Services.
(20) Director of Alcohol and Drug Abuse.
(21) Director of Rehabilitation.
(22) Chief Deputy, Department of Rehabilitation.
(23) Director of the Office of Statewide Health Planning and Development.
(24) Deputy, Health and Welfare Agency.
(25) Director, Department of Managed Health Care.
(26) Patient Advocate, Department of Managed Health Care.

SEC. 9. Section 6253.4 of the Government Code is amended to read:

6253.4. (a) Every agency may adopt regulations stating the procedures to be followed when making its records available in accordance with this section.

The following state and local bodies shall establish written guidelines for accessibility of records. A copy of these guidelines shall be posted in a conspicuous public place at the offices of these bodies, and a copy of the guidelines shall be available upon request free of charge to any person requesting that body's records:

Department of Motor Vehicles
Department of Consumer Affairs
Department of Transportation
Department of Real Estate
Department of Corrections
Department of the Youth Authority
Department of Justice
Department of Insurance
Department of Corporations
Department of Managed Health Care
Secretary of State
State Air Resources Board
Department of Water Resources
Department of Parks and Recreation
San Francisco Bay Conservation and Development Commission
State Board of Equalization
State Department of Health Services
Employment Development Department
State Department of Social Services
State Department of Mental Health
State Department of Developmental Services
State Department of Alcohol and Drug Abuse
Office of Statewide Health Planning and Development
Public Employees' Retirement System
Teachers' Retirement Board
Department of Industrial Relations
Department of General Services
Department of Veterans Affairs
Public Utilities Commission
California Coastal Commission
State Water Resources Control Board
San Francisco Bay Area Rapid Transit District
All regional water quality control boards
Los Angeles County Air Pollution Control District
Bay Area Air Pollution Control District
Golden Gate Bridge, Highway and Transportation District
Department of Toxic Substances Control
Office of Environmental Health Hazard Assessment

(b) Guidelines and regulations adopted pursuant to this section shall be consistent with all other sections of this chapter and shall reflect the intention of the Legislature to make the records accessible to the public. The guidelines and regulations adopted pursuant to this section shall not operate to limit the hours public records are open for inspection as prescribed in Section 6253.

SEC. 10. Section 6254.5 of the Government Code is amended to read:

6254.5. Notwithstanding any other provisions of the law, whenever a state or local agency discloses a public record which is otherwise exempt from this chapter, to any member of the public, this disclosure shall constitute a waiver of the exemptions specified in Sections 6254, 6254.7, or other similar provisions of law. For purposes of this section, ''agency'' includes a member, agent, officer, or employee of the agency acting within the scope of his or her membership, agency, office, or employment.

This section, however, shall not apply to disclosures:

(a) Made pursuant to the Information Practices Act (commencing with Section 1798 of the Civil Code) or discovery proceedings.

(b) Made through other legal proceedings or as otherwise required by law.

(c) Within the scope of disclosure of a statute which limits disclosure of specified writings to certain purposes.

(d) Not required by law, and prohibited by formal action of an elected legislative body of the local agency which retains the writings.

(e) Made to any governmental agency which agrees to treat the disclosed material as confidential. Only persons authorized in writing by the person in charge of the agency shall be permitted to obtain the information. Any information obtained by the agency shall only be used for purposes which are consistent with existing law.

(f) Of records relating to a financial institution or an affiliate thereof, if the disclosures are made to the financial institution or affiliate by a state agency responsible for the regulation or supervision of the financial institution or affiliate.

(g) Of records relating to any person that is subject to the jurisdiction of the Department of Corporations, if the disclosures are made to the person that is the subject of the records for the purpose of corrective action by that person, or if a corporation, to an officer, director, or other key personnel of the corporation for the purpose of corrective action, or to any other person to the extent necessary to obtain information from that person for the purpose of an investigation by the Department of Corporations.

(h) Made by the Commissioner of Financial Institutions under Section 1909, 8009, or 18396 of the Financial Code.

(i) Of records relating to any person that is subject to the jurisdiction of the Department of Managed Health Care, if the disclosures are made to the person that is the subject of the records for the purpose of corrective action by that person, or if a corporation, to an officer, director, or other key personnel of the corporation for the purpose of corrective action, or to any other person to the extent necessary to obtain information from that person for the purpose of an investigation by the Department of Managed Health Care.

SEC. 11. Section 11552 of the Government Code is amended to read:

11552. Effective January 1, 1988, an annual salary of eighty-five thousand four hundred two dollars ($85,402) shall be paid to each of the following:

(a) Commissioner of Financial Institutions.
(b) Commissioner of Corporations.
(c) Insurance Commissioner.
(d) Director of Transportation.
(e) Real Estate Commissioner.
(f) Director of Social Services.
(g) Director of Water Resources.
(h) Director of Corrections.
(i) Director of General Services.
(j) Director of Motor Vehicles.
(k) Director of the Youth Authority.
(*l*) Executive Officer of the Franchise Tax Board.
(m) Director of Employment Development.
(n) Director of Alcoholic Beverage Control.
(o) Director of Housing and Community Development.
(p) Director of Alcohol and Drug Abuse.
(q) Director of the Office of Statewide Health Planning and Development.
(r) Director of the Department of Personnel Administration.
(s) Chairperson and Member of the Board of Equalization.
(t) Secretary of the Trade and Commerce Agency.
(u) State Director of Health Services.
(v) Director of Mental Health.
(w) Director of Developmental Services.
(x) State Public Defender.
(y) Director of the California State Lottery.
(z) Director of Fish and Game.
(aa) Director of Parks and Recreation.
(ab) Director of Rehabilitation.
(ac) Director of Veterans Affairs.
(ad) Director of Consumer Affairs.
(ae) Director of Forestry and Fire Protection.
(af) The Inspector General pursuant to Section 6125 of the Penal Code.

(ag) Director of the Department of Managed Health Care.

The annual compensation provided by this section shall be increased in any fiscal year in which a general salary increase is provided for state employees. The amount of the increase provided by this section shall be comparable to, but shall not exceed, the percentage of the general salary increases provided for state employees during that fiscal year.

SEC. 12. Section 13975 of the Government Code is amended to read:

13975. The Business and Transportation Agency in state government is hereby renamed the Business, Transportation and Housing Agency. The agency consists of the Department of Alcoholic Beverage Control, the Department of the California Highway Patrol, the Department of Corporations, the Department of Housing and Community Development, the Department of Motor Vehicles, the Department of Real Estate, the Department of Transportation, the Department of Financial Institutions, the Department of Managed Health Care, the Stephen P. Teale Consolidated Data Center; and the California Housing Finance Agency is also located within the Business, Transportation and Housing Agency, as specified in Division 31 (commencing with Section 50000) of the Health and Safety Code.

SEC. 13. Section 13975.2 of the Government Code is amended to read:

13975.2. (a) This section applies to every action brought in the name of the people of the State of California by the Director of the Department of Managed Health Care before, on, or after the effective date of this section, when enforcing provisions of those laws administered by the Director of the Department of Managed Health Care which authorize the Director of Managed Health Care to seek a permanent or preliminary injunction, restraining order, or writ of mandate, or the appointment of a receiver, monitor, conservator, or other designated fiduciary or officer of the court. Upon a proper showing, a permanent or preliminary injunction, restraining order, or writ of mandate shall be granted and a receiver, monitor, conservator, or other designated fiduciary or officer of the court may be appointed for the defendant or the defendant’s assets, or any other ancillary relief may be granted as appropriate. The court may order that the expenses and fees of the receiver, monitor, conservator, or other designated fiduciary or officer of the court, be paid from the property held by the receiver, monitor, conservator, or other court designated fiduciary or officer, but neither the state, the Business, Transportation and Housing Agency, nor the Department of Managed Health Care shall be liable for any of those expenses and fees, unless expressly provided for by written contract.

(b) The receiver, monitor, conservator, or other designated fiduciary or officer of the court may do any of the following subject to the direction of the court:

(1) Sue for, collect, receive, and take into possession all the real and personal property derived by any unlawful means, including property with which that property or the proceeds thereof has been commingled if that property or the proceeds thereof cannot be identified in kind because of the commingling.

(2) Take possession of all books, records, and documents relating to any unlawfully obtained property and the proceeds thereof. In addition, they shall have the same right as a defendant to request, obtain, inspect, copy, and obtain copies of books, records, and documents maintained by third parties that relate to unlawfully obtained property and the proceeds thereof.

(3) Transfer, encumber, manage, control, and hold all property subject to the receivership, including the proceeds thereof, in the manner directed or ratified by the court.

(4) Avoid a transfer of any interest in any unlawfully obtained property including the proceeds thereof to any person who committed, aided or abetted, or participated in the commission of unlawful acts or who had knowledge that the property had been unlawfully obtained.

(5) Avoid a transfer of any interest in any unlawfully obtained property including the proceeds thereof made with the intent to hinder or delay the recovery of that property or any interest in it by the receiver or any person from whom the property was unlawfully obtained.

(6) Avoid a transfer of any interest in any unlawfully obtained property including the proceeds thereof that was made within one year before the date of the entry of the receivership order if less than a reasonably equivalent value was given in exchange for the transfer, except that a bona fide transferee for value and without notice that the property had been unlawfully obtained may retain the interest transferred until the value given in exchange for the transfer is returned to the transferee.

(7) Avoid a transfer of any interest in any unlawfully obtained property including the proceeds thereof made within 90 days before the date of the entry of the receivership order to a transferee from whom the defendant unlawfully obtained some property if (A) the receiver establishes that the avoidance of the transfer will promote a fair pro rata distribution of restitution among all people from whom defendants unlawfully obtained property and (B) the transferee cannot establish that the specific property transferred was the same property that had been unlawfully obtained from the transferee.

(8) Exercise any power authorized by statute or ordered by the court.

(c) No person with actual or constructive notice of the receivership shall interfere with the discharge of the receiver's duties.

(d) No person may file any action or enforce or create any lien, or cause to be issued, served, or levied any summons, subpoena, attachment, or writ of execution against the receiver or any property subject to the receivership without first obtaining prior court approval upon motion with notice to the receiver and the Director of the Department of Managed Health Care. Any legal procedure described in this subdivision commenced without prior court approval is void except as to a bona fide purchaser or encumbrancer for value and without notice of the receivership. No person without notice of the receivership shall incur any liability for commencing or maintaining any legal procedure described by this subdivision.

(e) The court shall have jurisdiction of all questions arising in the receivership proceedings and may make any orders and judgments as may be required, including orders after noticed motion by the receiver to avoid transfers as provided in paragraphs (4), (5), (6), and (7) of subdivision (b).

(f) This section is cumulative to all other provisions of law.

(g) If any provision of this section or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of this section that can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

(h) The recordation of a copy of the receivership order imparts constructive notice of the receivership in connection with any matter involving real property located in the county in which the receivership order is recorded.

SEC. 14. Section 21661 of the Government Code is amended to read:

21661. (a) The board shall contract with carriers offering long-term care insurance plans and enter into health care service plan contracts covering long-term care.

The long-term care insurance plans and health care service plan contracts covering long-term care shall be made available periodically during open enrollment periods determined by the board.

(b) The board shall award contracts to carriers who are qualified to provide long-term care benefits, and may develop and administer self-funded long-term care insurance plans. The board may offer one or more long-term care insurance plans or health care service plan contracts covering long-term care and may offer service or indemnity-type plans.

(c) The long-term care insurance plans and health care service plan contracts covering long-term care shall include home, community, and institutional care and shall, to the extent determined

by the board, provide substantially equivalent coverage to that required under Chapter 2.6 (commencing with Section 10230) of Part 2 of Division 2 of the Insurance Code, if the carrier has been approved by the Department of Managed Health Care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(d) The classes of persons who shall be eligible to enroll are:

(1) Active and retired members and annuitants of the Public Employees' System, and their spouses, their parents, and their spouses' parents.

(2) Active and retired members and annuitants of any county or district subject to the County Employees Retirement Law of 1937, and their spouses, their parents, and their spouses' parents.

(3) Active and retired members and annuitants of the State Teachers' Retirement System, and their spouses, their parents, and their spouses' parents.

(4) Active employees and retirees and annuitants of any public agency that is a contracting agency under this part or Part 5 (commencing with Section 22751), and their spouses, their parents, and their spouses' parents.

(5) Active and retired members and annuitants of the Judges' Retirement System, and their spouses, their parents, and their spouses' parents.

(6) Active and retired members and annuitants of the Judges' Retirement System II, and their spouses, their parents, and their spouses' parents.

(7) Active and retired members and annuitants of the Legislators' Retirement System, and their spouses, their parents, and their spouses' parents.

(8) Members of the California Assembly and Senate and their spouse, their parents and their spouse's parents.

(9) Active and retired members and annuitants, and other classes of employees of other public employee retirement systems or public employers as the board determines may be eligible under the standards the board may prescribe, and their spouses, their parents, and their spouses' parents.

(10) Active employees and retirees and annuitants of any agency specified in paragraphs (1) through (9) who reside in the United States, its territories and possessions, or in a country in which a provider network can be established comparable in quality and effectiveness to those established in the United States.

(e) Any California public agency or retirement system may contract with the board to extend the provisions of this article to its active and retired employees and annuitants.

(f) Irrespective of paragraphs (1) through (10) of subdivision (d), no person shall be enrolled unless he or she meets the eligibility and underwriting criteria established by the board.

(g) Irrespective of paragraphs (1) through (10) of subdivision (d), enrollment of active employees of the State of California shall be subject to Section 19867.

(h) The board shall establish eligibility criteria for enrollment, establish appropriate underwriting criteria for potential enrollees, define the scope of covered benefits, define the criteria to receive benefits, and set any other standards as needed.

(i) The full cost of enrollment in a long-term care insurance plan or in health care service plan contracts covering long-term care shall be paid by the enrollees.

(j) The long-term care insurance plans and health care service plan contracts covering long-term care shall not become part of, or subject to, the retirement or health benefits programs administered by the system.

(k) For any self-funded long-term care plan developed by the board, the premiums shall be deposited in the Public Employees' Long-term Care Fund.

SEC. 15. Section 31696.1 of the Government Code is amended to read:

31696.1. (a) The board of retirement may provide a long-term care insurance program for retired members and their spouses, their parents, and their spouses' parents.

(b) Subject to Section 31696.5, the board may permit active members and their spouses, their parents, and their spouses' parents to enroll in the long-term care insurance program.

(c) The long-term care insurance plan shall be made available periodically during open enrollment periods determined by the board.

(d) The board shall award contracts to carriers who are qualified to provide long-term care benefits.

(e) The long-term care insurance plan shall include home, community, and institutional care and shall provide substantially equivalent coverage to that required under Chapter 2.6 (commencing with Section 10230) of Part 2 of Division 2 of the Insurance Code and shall meet those requirements set forth in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). However, the Department of Managed Health Care shall have no jurisdiction over the insurance plan authorized by this article.

(f) Notwithstanding subdivision (a), no person shall be enrolled unless he or she meets the eligibility and underwriting criteria approved by the board.

(g) The board shall approve eligibility criteria for enrollment, approve appropriate underwriting criteria for potential enrollees, approve the scope of covered benefits, approve the criteria to receive benefits, and approve any other standards as needed.

SEC. 16. Section 37615.1 of the Government Code is amended to read:

37615.1. Each local municipal hospital shall have and may exercise the following powers:

(a) To purchase, receive, have, take, hold, lease, use, and enjoy property of every kind and description within and without the limits of the municipality, and to control, dispose of, convey, and encumber the same and create a leasehold interest in the same for the benefit of the hospital.

(b) To establish one or more trusts for the benefit of the municipal hospital, to administer any trusts declared or created for the benefit of the municipal hospital, to designate one or more trustees for trusts created by the municipality, to receive by gift, devise, or bequest, and hold in trust or otherwise, property, including corporate securities of all kinds, situated in this state or elsewhere, and where not otherwise provided, dispose of the same for the benefit of the municipal hospital.

(c) To employ any officers and employees, including architects and consultants, the board of trustees deems necessary to carry on properly the business of the municipal hospital.

(d) To do any and all things which an individual might do which are necessary for, and to the advantage of, a hospital and a nurses' training school, or a child-care facility for the benefit of employees of the hospital or residents of the municipality.

(e) To establish, maintain and operate, or provide assistance in the operation of, one or more health facilities or health services, including, but not limited to, outpatient programs, services and facilities, retirement programs, services and facilities, chemical dependency programs, services and facilities, or other health care programs, services and facilities and activities at any location within or without the municipality for the benefit of the hospital and the people served by the municipal hospital.

''Health facilities,'' as used in this subdivision, means those facilities defined in either Section 15432 of this code or Section 1250 of the Health and Safety Code and specifically includes freestanding chemical dependency recovery units.

(f) To do any and all other acts and things necessary to carry out this division.

(g) To acquire, maintain, and operate ambulances or ambulance services within and without the municipality.

(h) To establish, maintain, and operate, or provide assistance in the operation of, free clinics, diagnostic and testing centers, health education programs, wellness and prevention programs, rehabilitation, aftercare, and any other health care services provider, groups, and organizations which are necessary for the maintenance of good physical and mental health in the communities served by the municipal hospital.

(i) To establish and operate in cooperation with its medical staff a coinsurance plan between the municipal hospital and the members of its attending medical staff.

(j) With the approval of the city council, to establish, maintain, and carry on its activities through one or more corporations, joint ventures, or partnerships for the benefit of the municipal hospital.

(k) With the consent of the city council, to contract for bond insurance, letters of credit, remarketing services, and other forms of credit enhancement and liquidity support for its bonds, notes, and other indebtedness and to enter into reimbursement agreements, monitoring agreements, remarketing agreements, and similar ancillary contracts in connection therewith.

(*l*) To establish, maintain, operate, participate in, or manage capitated health care plans, health maintenance organizations, preferred provider organizations, and other managed health care systems and programs properly licensed by the Department of Insurance or the Department of Managed Health Care, at any location within or without the municipality for the benefit of residents of communities served by the hospital. However, no such activity shall be deemed to result in or constitute the giving or lending of the municipality's credit, assets, surpluses, cash, or tangible goods to, or in aid of, any person, association, or corporation in violation of Section 6 of Article XVI of the California Constitution.

Nothing in this section shall authorize activities which corporations and other artificial legal entities are prohibited from conducting by Section 2400 of the Business and Professions Code.

Any agreement to provide health care coverage which is a health care service plan, as defined in subdivision (f) of Section 1345 of the Health and Safety Code, shall be subject to the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, unless exempted pursuant to Section 1343 or 1349.2 of the Health and Safety Code.

A municipal hospital shall not provide health care coverage for any employee of an employer operating within the service area of the municipal hospital, unless the Legislature specifically authorizes, or has authorized the coverage.

This section shall not authorize any municipal hospital to contribute its facilities to any joint venture that could result in transfer of the facilities from city ownership.

(m) To provide health care coverage to members of the hospital's medical staff, employees of the medical staff members, and the dependents of both groups, on a self-pay basis.

(n) With the consent of the city council, to establish, maintain, and carry on its activities through one or more corporations, joint ventures, or partnerships for the benefit of the municipal hospital.

(o) With the consent of the city council, to transfer, with or without consideration, any part of its assets to one or more nonprofit

corporations to operate and maintain the assets for the benefits of the area served by the hospital. The initial members of the board of directors of the nonprofit corporation or corporations shall be approved by the city council and shall be residents of the city.

(p) Nothing in this section, including, but not limited to, subdivision (e), shall be construed to permit a municipal hospital to operate or be issued a single consolidated license to operate a separate physical plant as a skilled nursing facility or an intermediate care facility which is not located within the boundaries of the municipality.

SEC. 17. Section 1317.2a of the Health and Safety Code is amended to read:

1317.2a. (a) A hospital which has a legal obligation, whether imposed by statute or by contract, to the extent of that contractual obligation, to any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, a county, or an employer to provide care for a patient under the circumstances specified in Section 1317.2 shall receive that patient to the extent required by the applicable statute or by the terms of the contract, or, when the hospital is unable to accept a patient for whom it has a legal obligation to provide care whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care.

(b) A county hospital shall accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2 and who is determined by the county to be eligible to receive health care services required under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, unless the hospital does not have appropriate bed capacity, medical personnel, or equipment required to provide care to the patient in accordance with accepted medical practice. When a county hospital is unable to accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care. The obligation to make appropriate arrangements as set forth in this subdivision does not mandate a level of service or payment, modify the county's obligations under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, create a cause of action, or limit a county's flexibility to manage county health systems within available resources. However, the county's flexibility shall not diminish a county's responsibilities under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code or the requirements contained in Chapter 2.5 (commencing with Section 1440).

(c) The receiving hospital shall provide personnel and equipment reasonably required in the exercise of good medical practice for the care of the transferred patient.

(d) Any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, or employer which has a statutory or contractual obligation to provide or indemnify emergency medical services on behalf of a patient shall be liable, to the extent of the contractual obligation to the patient, for the reasonable charges of the transferring hospital and the treating physicians for the emergency services provided pursuant to this article, except that the patient shall be responsible for uncovered services, or any deductible or copayment obligation. Notwithstanding this section, the liability of a third-party payor which has contracted with health care providers for the provision of these emergency services shall be set by the terms of that contract. Notwithstanding this section, the liability of a third-party payor that is licensed by the Insurance Commissioner or the Director of the Department of Managed Health Care and has a contractual obligation to provide or indemnify emergency medical services under a contract which covers a subscriber or an enrollee shall be determined in accordance with the terms of that contract and shall remain under the sole jurisdiction of that licensing agency.

(e) A hospital which has a legal obligation to provide care for a patient as specified by subdivision (a) of Section 1317.2a to the extent of its legal obligation, imposed by statute or by contract to the extent of that contractual obligation, which does not accept transfers of, or make other appropriate arrangements for, medically stable patients in violation of this article or regulations adopted pursuant thereto shall be liable for the reasonable charges of the transferring hospital and treating physicians for providing services and care which should have been provided by the receiving hospital.

(f) Subdivisions (d) and (e) do not apply to county obligations under Section 17000 of the Welfare and Institutions Code.

(g) Nothing in this section shall be interpreted to require a hospital to make arrangements for the care of a patient for whom the hospital does not have a legal obligation to provide care.

SEC. 18. Section 1317.6 of the Health and Safety Code is amended to read:

1317.6. (a) Hospitals found by the state department to have committed or to be responsible for a violation of this article or the regulations adopted pursuant thereto shall be subject to a civil penalty by the state department in an amount not to exceed twenty-five thousand dollars ($25,000) for each hospital violation. In determining the amount of the fine for a hospital violation, the state department shall take into account all of the following:

(1) Whether the violation was knowing or unintentional.

(2) Whether the violation resulted or was reasonably likely to result in a medical hazard to the patient.

(3) The frequency or gravity of the violation.

(4) Other civil fines which have been imposed as a result of the violation under Section 1395 of Title 42 of the United States Code.

(b) Notwithstanding this section, the director shall refer any alleged violation by a hospital owned and operated by a health care service plan involving a plan member or enrollee to the Department of Managed Health Care unless the director determines the complaint is without reasonable basis. The Department of Managed Health Care shall have sole authority and responsibility to enforce this article with respect to violations involving hospitals owned and operated by health care service plans in their treatment of plan members or enrollees.

(c) Physicians and surgeons found by the board to have committed, or to be responsible for, a violation of this article or the regulations adopted pursuant thereto shall be subject to any and all penalties which the board may lawfully impose and may be subject to a civil penalty by the board in an amount not to exceed five thousand dollars ($5,000) for each violation. A civil penalty imposed under this subdivision shall not duplicate federal fines, and the board shall credit any federal fine against a civil penalty imposed under this subdivision.

(d) The board may impose fines when it finds any of the following:

(1) The violation was knowing or willful.

(2) The violation was reasonably likely to result in a medical hazard.

(3) There are repeated violations.

(e) It is the intent of the Legislature that the state department has primary responsibility for regulating the conduct of hospital emergency departments and that fines imposed under this section should not be duplicated by additional fines imposed by the federal government as a result of the conduct which constituted a violation of this section. To effectuate the Legislature’s intent, the Governor shall inform the Secretary of the federal Department of Health and Human Services of the enactment of this section and request the federal department to credit any penalty assessed under this section against any subsequent civil monetary penalty assessed pursuant to Section 1395dd of Title 42 of the United States Code for the same violation.

(f) There shall be a cumulative maximum limit of thirty thousand dollars ($30,000) in fines assessed against hospitals under this article and under Section 1395dd of Title 42 of the United States Code for the same circumstances. To effectuate this cumulative maximum limit, the state department shall do both of the following:

(1) As to state fines assessed prior to the final conclusion, including judicial review, if available, of an action against a hospital by the

federal Department of Health and Human Services under Section 1395dd of Title 42 of the United States Code (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), remit and return to the hospital within 30 days after conclusion of the federal action, that portion of the state fine necessary to assure that the cumulative maximum limit is not exceeded.

(2) Immediately credit against state fines assessed after the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1395dd of Title 42 of the United States Code, which results in a fine against a hospital (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), the amount of the federal fine, necessary to assure the cumulative maximum limit is not exceeded.

(g) Any hospital found by the state department pursuant to procedures established by the state department to have committed a violation of this article or the regulations adopted hereunder may have its emergency medical service permit revoked or suspended by the state department.

(h) Any administrative or medical personnel who knowingly and intentionally violates any provision of this article, may be charged by the local district attorney with a misdemeanor.

(i) Notification of each violation found by the state department of the provisions of this article or the regulations adopted hereunder shall be sent by the state department to the Joint Commission for the Accreditation of Hospitals, the state emergency medical services authority, and local emergency medical services agencies.

(j) Any person who suffers personal harm and any medical facility which suffers a financial loss as a result of a violation of this article or the regulations adopted hereunder may recover, in a civil action against the transferring or receiving hospital, damages, reasonable attorney’s fees, and other appropriate relief. Transferring and receiving hospitals from which inappropriate transfers of persons are made or refused in violation of this article and the regulations adopted hereunder shall be liable for the reasonable charges of the receiving or transferring hospital for providing the services and care which should have been provided. Any person potentially harmed by a violation of this article or the regulations adopted hereunder, or the local district attorney or the Attorney General, may bring a civil action against the responsible hospital or administrative or medical personnel, to enjoin the violation, and if the injunction issues, the court shall award reasonable attorney’s fees. The provisions of this subdivision are in addition to other civil remedies and do not limit the availability of the other remedies.

(k) The civil remedies established by this section do not apply to violations of any requirements established by any county or county agency.

SEC. 19. Section 1341 of the Health and Safety Code is amended to read:

1341. (a) There is in state government, in the Business, Transportation and Housing Agency, a Department of Managed Health Care that has charge of the execution of the laws of this state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.

(b) The chief officer of the Department of Managed Health Care is the Director of the Department of Managed Health Care. The director shall be appointed by the Governor and shall hold office at the pleasure of the Governor. The director shall receive an annual salary as fixed in the Government Code. Within 15 days from the time of the director's appointment, the director shall take and subscribe to the constitutional oath of office and file it in the office of the Secretary of State.

(c) The director shall be responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department. The director has and may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the laws described in subdivision (a).

SEC. 20. Section 1341.1 of the Health and Safety Code is amended to read:

1341.1. The director shall have his or her principal office in the City of Sacramento, and may establish branch offices in the City and County of San Francisco, in the City of Los Angeles, and in the City of San Diego. The director shall from time to time obtain the necessary furniture, stationery, fuel, light, and other proper conveniences for the transaction of the business of the Department of Managed Health Care.

SEC. 21. Section 1341.2 of the Health and Safety Code is amended to read:

1341.2. In accordance with the laws governing the state civil service, the director shall employ and, with the approval of the Department of Finance, fix the compensation of such personnel as the director needs to discharge properly the duties imposed upon the director by law, including, but not limited to, a chief deputy, a public information officer, a chief enforcement counsel, and legal counsel to act as the attorney for the director in actions or proceedings brought by or against the director under or pursuant to any provision of any law under the director's jurisdiction, or in which the director

joins or intervenes as to a matter within the director's jurisdiction, as a friend of the court or otherwise, and stenographic reporters to take and transcribe the testimony in any formal hearing or investigation before the director or before a person authorized by the director. The personnel of the Department of Managed Health Care shall perform such duties as the director assigns to them. Such employees as the director designates by rule or order shall, within 15 days after their appointments, take and subscribe to the constitutional oath of office and file it in the office of the Secretary of State.

SEC. 22. Section 1341.3 of the Health and Safety Code is amended to read:

1341.3. The director shall adopt a seal bearing the inscription: ''Director, Department of Managed Health Care, State of California.'' The seal shall be affixed to or imprinted on all orders and certificates issued by him or her and such other instruments as he or she directs. All courts shall take judicial notice of this seal.

SEC. 23. Section 1341.6 of the Health and Safety Code is amended to read:

1341.6. (a) The Attorney General shall render to the director opinions upon all questions of law, relating to the construction or interpretation of any law under the director's jurisdiction or arising in the administration thereof, that may be submitted to the Attorney General by the director and upon the director's request shall act as the attorney for the director in actions and proceedings brought by or against the director under or pursuant to any provision of any law under the director's jurisdiction.

(b) Sections 11041, 11042, and 11043 of the Government Code do not apply to the Director of the Department of Managed Health Care.

SEC. 24. Section 1341.7 of the Health and Safety Code is amended to read:

1341.7. (a) Neither the director nor any of the director's assistants, clerks, or deputies shall be interested as a director, officer, shareholder, member other than a member of an organization formed for religious purposes, partner, agent, or employee of any person who, during the period of the official's or employee's association with the Department of Managed Health Care, was licensed or applied for a license as a health care service plan under this chapter.

(b) Nothing contained in subdivision (a) shall prohibit the holdings or purchasing of any securities by the director, an assistant, clerk, or deputy in accordance with rules which shall be adopted for the purpose of protecting the public interest and avoiding conflicts of interest.

(c) Nothing in this section shall prohibit or preclude the director or any of the director's assistants, clerks, or deputies or any employee of the Department of Managed Health Care from obtaining health

care services as a subscriber or an enrollee from a plan licensed under this chapter, subject to any rules that may be adopted hereunder or pursuant to proper authority.

SEC. 25. Section 1342.3 of the Health and Safety Code is amended to read:

1342.3. The director shall, in conjunction with the Advisory Committee on Managed Health Care, undertake a study to consider the feasibility and benefit of consolidating into the Department of Managed Health Care the regulation of other health insurers providing insurance through indemnity, preferred provider organization, and exclusive provider organization products, as well as through other managed care products regulated by the Department of Insurance. The results of the study along with the recommendations of the director shall be incorporated into a report to the Governor and the Legislature no later than December 31, 2001.

SEC. 26. Section 1342.5 of the Health and Safety Code is amended to read:

1342.5. The director shall consult with the Insurance Commissioner prior to adopting any regulations applicable to health care service plans subject to this chapter and nonprofit hospital service plans subject to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code and other entities governed by the Insurance Code for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to these plans and entities by the Insurance Commissioner and the Director of the Department of Managed Health Care.

SEC. 27. Section 1343 of the Health and Safety Code is amended to read:

1343. (a) This chapter shall apply to health care service plans and specialized health care service plan contracts as defined in subdivisions (f) and (o) of Section 1345.

(b) The director may by the adoption of rules or the issuance of orders deemed necessary and appropriate, either unconditionally or upon specified terms and conditions or for specified periods, exempt from this chapter any class of persons or plan contracts if the director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter.

(c) The director, upon request of the Director of Health Services, shall exempt from this chapter any county-operated pilot program contracting with the State Department of Health Services pursuant to Article 7 (commencing with Section 14490) of Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code. The director may exempt non-county-operated pilot programs upon request of the State Director of Health Services. Those exemptions may be subject to conditions the Director of Health Services deems appropriate.

(d) Upon the request of the Director of Mental Health, the director may exempt from this chapter any mental health plan contractor or any capitated rate contract under Part 2.5 (commencing with Section 5775) of Division 5 of the Welfare and Institutions Code. Those exemptions may be subject to conditions the Director of Mental Health deems appropriate.

(e) This chapter shall not apply to:

(1) A person organized and operating pursuant to a certificate issued by the Insurance Commissioner unless the entity is directly providing the health care service through those entity-owned or contracting health facilities and providers, in which case this chapter shall apply to the insurer's plan and to the insurer.

(2) A plan directly operated by a bona fide public or private institution of higher learning which directly provides health care services only to its students, faculty, staff, administration, and their respective dependents.

(3) A nonprofit corporation formed under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(4) A person who does all of the following:

(A) Promises to provide care for life or for more than one year in return for a transfer of consideration from, or on behalf of, a person 60 years of age or older.

(B) Has obtained a written license pursuant to Chapter 2 (commencing with Section 1250) or Chapter 3.2 (commencing with Section 1569).

(C) Has obtained a certificate of authority from the State Department of Social Services.

(5) The Major Risk Medical Insurance Board when engaging in activities under Chapter 8 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code, and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code.

(6) The California Small Group Reinsurance Fund.

SEC. 28. Section 1346.5 of the Health and Safety Code is amended to read:

1346.5. If the director determines that an entity purporting to be a health care service plan exempt from the provisions of Section 740 of the Insurance Code is not a health care service plan, the director shall inform the Department of Insurance of that finding. However, if the director determines that an entity is a health care service plan, the director shall prepare and maintain for public inspection a list of those persons or entities described in subdivision (a) of Section 740 of the Insurance Code, which are not subject to the jurisdiction of another agency of this or another state or the federal government and which the director knows to be operating in the state. There shall be

no liability of any kind on the part of the state, the director, and employees of the Department of Managed Health Care for the accuracy of the list or for any comments made with respect to it. Additionally, any solicitor or solicitor firm who advertises or solicits health care service plan coverage in this state described in subdivision (a) of Section 740 of the Insurance Code, which is provided by any person or entity described in subdivision (c) of that section, and where such coverage does not meet all pertinent requirements specified in the Insurance Code, and which is not provided or completely underwritten, insured or otherwise fully covered by a health care service plan, shall advise and disclose to any purchaser, prospective purchaser, covered person or entity, all financial and operational information relative to the content and scope of the plan and, specifically, as to the lack of plan coverage.

SEC. 29. Section 1347 of the Health and Safety Code is amended to read:

1347. (a) (1) There is established in the Department of Managed Health Care the Advisory Committee on Managed Health Care consisting of 22 members, as follows:

(A) The director.

(B) Eleven members appointed by the Governor, to be appointed as follows:

(i) A physician and surgeon with five years' experience in providing services to enrollees of a full service health care service plan.

(ii) An executive officer or medical director of a full service health care service plan.

(iii) A person with expertise and five years' experience in an administrative capacity of a health care service plan.

(iv) An executive officer with five years' experience with a contracting medical group.

(v) A medical director with a contracting medical group.

(vi) A member of the department's Financial Solvency Standards Board.

(vii) A physician-executive from an academic medical center.

(viii) A member of the department's clinical advisory panel.

(ix) A medical director or senior officer with a dental service plan.

(x) A medical director or senior officer with a vision service plan.

(xi) A medical director or senior officer with a mental health service plan.

(C) (i) Ten public members, four of whom shall be appointed by the Governor and three each by the Speaker of the Assembly and the Senate Committee on Rules who have a broad understanding of health and managed care issues and who have no financial interest in the delivery of health care services or in plans except that public

members may be enrollees in a health care service plan or specialized health care service plan.

(ii) Of the public members appointed by the Governor, at least two of these members shall have significant academic backgrounds in the area.

(iii) Of the members appointed by the Speaker of the Assembly and the Senate Committee on Rules at least one public member appointed by each appointing power shall represent a health care consumer advocacy organization, with the Speaker's appointee representing an organization that devotes at least 50 percent of its time to resolving consumer complaints. The Speaker of the Assembly and the Senate Committee on Rules shall also each appoint one public member with significant background experience in the area of health care.

(D) With respect to members appointed by the Governor, if members with the qualifications specified in this subdivision are not available for service, other factors such as relevant health care experience and education shall be substituted at the discretion of the Governor.

(2) Except as otherwise specified in this paragraph, all appointments to the committee shall be for a period of three years. The initial appointments shall commence January 1, 2000. Of the initial appointments made by the Governor, four shall serve for a term of one year and five shall serve for a term of two years, as designated by the Governor. Of the initial appointments made by the Speaker of the Assembly and the Senate Committee on Rules, one member appointed by each appointing power shall serve for a term of one year, and one shall serve for a term of two years, as designated by the appointing power.

(b) The committee shall meet at least quarterly and at the call of the chairperson. The director or the director's designee shall be chairperson of the committee. The committee may establish its own rules and procedures. All members shall serve without compensation, but the consumer representatives and public members shall be reimbursed from department funds for expenses actually and necessarily incurred by them in the performance of their duties.

(c) The purpose of the committee is to assist and advise the director in the implementation of the director's duties under this chapter and to make recommendations that it deems beneficial and appropriate as to how the department may best serve the people of the state. The committee shall produce an Internet-accessible annual public report that will, at a minimum, contain recommendations made to the director. At a minimum, the report shall include the following:

(1) Recommendations to the director on producing a report card to the public on the comparative performance of the managed care

organizations overseen by the department, including health care service plans and subcontracting providers, building on the work of the private sector and other government entities and including complaint information received by the state.

(2) (A) The committee's top five recommendations for improving the health care delivery system and quality of care taking into consideration information received from the public.

(B) To assist the committee in formulating its recommendations, the views and suggestions of the public should be solicited. The committee shall accompany the director at least twice each year for public hearings (with at least one in northern California and at least one in southern California).

(C) This report shall be delivered to the director, the Governor, and to the appropriate policy committees of the Legislature.

(d) The director shall consult with the advisory committee on regulations and the recommendations of the committee shall be made a part of the record with regard to such regulations. The committee shall be given at least 40 days to review and comment on regulations prior to setting a notice of hearing for proposed regulations. Nothing in this subdivision prohibits the director from promulgating emergency regulations pursuant to the provisions of the Administrative Procedure Act. The director shall discuss budget changes relating to the administration of this chapter with the committee, and the committee may make recommendations to the director regarding the proposed budget changes.

SEC. 30. Section 1357.16 of the Health and Safety Code is amended to read:

1357.16. (a) Health care service plans may enter into contractual agreements with qualified associations, as defined in subdivision (b), under which these qualified associations may assume responsibility for performing specific administrative services, as defined in this section, for qualified association members. Health care service plans that enter into agreements with qualified associations for assumption of administrative services shall establish uniform definitions for the administrative services that may be provided by a qualified association or its third-party administrator. The health care service plan shall permit all qualified associations to assume one or more of these functions when the health care service plan determines the qualified association demonstrates the administrative capacity to assume these functions.

For the purposes of this section, administrative services provided by qualified associations or their third-party administrators shall be services pertaining to eligibility determination, enrollment, premium collection, sales, or claims administration on a per-claim basis that would otherwise be provided directly by the health care service plan or through a third-party administrator on a commission basis or an agent or solicitor work force on a commission basis.

Each health care service plan that enters into an agreement with any qualified association for the provision of administrative services shall offer all qualified associations with which it contracts the same premium discounts for performing those services the health care service plan has permitted the qualified association or its third-party administrator to assume. The health care service plan shall apply these uniform discounts to the health care service plan's risk adjusted employee risk rates after the health plan has determined the qualified association's risk adjusted employee risk rates pursuant to Section 1357.12. The health care service plan shall report to the Department of Managed Health Care its schedule of discount for each administrative service.

In no instance may a health care service plan provide discounts to qualified associations that are in any way intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association. In addition to any other remedies available to the director to enforce this chapter, the director may declare a contract between a health care service plan and a qualified association for administrative services pursuant to this section null and void if the director determines any discounts provided to the qualified association are intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association.

(b) For the purposes of this section, a qualified association is a nonprofit corporation comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, that conforms to all of the following requirements:

(1) It accepts for membership any individual or small employer meeting its membership criteria.

(2) It does not condition membership directly or indirectly on the health or claims history of any person.

(3) It uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association.

(4) It is organized and maintained in good faith for purposes unrelated to insurance.

(5) It existed on January 1, 1972, and has been in continuous existence since that date.

(6) It has a constitution and bylaws or other analogous governing documents that provide for election of the governing board of the association by its members.

(7) It offered, marketed, or sold health coverage to its members for 20 continuous years prior to January 1, 1993.

(8) It agrees to offer only to association members any plan contract.

(9) It agrees to include any member choosing to enroll in the plan contract offered by the association, provided that the member agrees to make required premium payments.

(10) It complies with all provisions of this article.

(11) It had at least 10,000 enrollees covered by association sponsored plans immediately prior to enactment of Chapter 1128 of the Statutes of 1992.

(12) It applies any administrative cost at an equal rate to all members purchasing coverage through the qualified association.

(c) A qualified association shall comply with Section 1357.52.

(d) The department shall monitor compliance with this section and report the impact of any noncompliance to the Assembly Insurance Committee and the Senate Insurance Committee on January 1, 2002.

(e) This section shall remain in effect only until January 1, 2003, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2003, deletes or extends that date.

SEC. 31. Section 1363 of the Health and Safety Code is amended to read:

1363. (a) The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the director, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan, including coverage for acute care and subacute care.

(2) The exceptions, reductions, and limitations that apply to the plan.

(3) The full premium cost of the plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member’s family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A) (i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the plan or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under

the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient's choice of primary care or specialty care physician based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 5.55 (commencing with Section 1374.30).

(17) A notice as required by Section 1364.5.

(b) (1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.
(B) Lifetime maximums.
(C) Professional services.
(D) Outpatient services.
(E) Hospitalization services.
(F) Emergency health coverage.
(G) Ambulance services.
(H) Prescription drug coverage.
(I) Durable medical equipment.
(J) Mental health services.
(K) Chemical dependency services.
(L) Home health services.
(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(c) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan so examined or sold.

(e) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan. If the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(g) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract that may be less favorable to subscribers or enrollees.

(h) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare program pursuant to Title XVIII and Title XIX of the Social Security Act.

SEC. 32. Section 1367.25 of the Health and Safety Code is amended to read:

1367.25. (a) Every group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, and every individual health care service plan contract that is amended, renewed, or delivered on or after January 1, 2000, except for a specialized health care service plan contract, shall provide

coverage for the following, under general terms and conditions applicable to all benefits:

(1) A health care service plan contract that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration approved prescription contraceptive methods designated by the plan. In the event the patient's participating provider, acting within his or her scope of practice, determines that none of the methods designated by the plan is medically appropriate for the patient's medical or personal history, the plan shall also provide coverage for another federal Food and Drug Administration approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.

(2) Outpatient prescription benefits for an enrollee shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(b) Notwithstanding any other provision of this section, a religious employer may request a health care service plan contract without coverage for federal Food and Drug Administration approved contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a health care service plan contract shall be provided without coverage for contraceptive methods.

(1) For purposes of this section, a ''religious employer'' is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization as described in Section 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

(2) Every religious employer that invokes the exemption provided under this section shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.

(c) Nothing in this section shall be construed to exclude coverage for prescription contraceptive supplies ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for prescription contraception that is necessary to preserve the life or health of an enrollee.

(d) Nothing in this section shall be construed to deny or restrict in any way any existing right or benefit provided under law or by contract.

(e) Nothing in this section shall be construed to require an individual or group health care service plan to cover experimental or investigational treatments.

SEC. 33. Section 1367.695 of the Health and Safety Code is amended to read:

1367.695. (a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gynecologists warrants direct access to obstetrical and gynecological physician services.

(b) Commencing January 1, 1999, every health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

(c) In implementing this section, a health care service plan may establish reasonable provisions governing utilization protocols and the use of obstetricians and gynecologists, or family practice physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or independent practice association, provided that these provisions shall be consistent with the intent of this section and shall be those customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and shall not be more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services, but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family practice physician and surgeon, as provided for in subdivision (b), to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for followup care.

(d) This section shall not be construed to diminish the provisions of Section 1367.69.

(e) The Department of Managed Health Care shall report to the Legislature, on or before January 1, 2000, on the implementation of this section.

SEC. 34. Section 1368.02 of the Health and Safety Code is amended to read:

1368.02. (a) The director shall establish and maintain a toll-free telephone number for the purpose of receiving complaints regarding health care service plans regulated by the director.

(b) Every health care service plan shall publish the department's toll-free telephone number, the California Relay Service's toll-free telephone numbers for the hearing and speech impaired, the plan's telephone number, and the department's Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number, and the department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

''The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number (insert telephone number) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (insert website address) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at [plan's telephone number] and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.''

(c) (1) There is within the department an Office of Patient Advocate, which shall be known and may be cited as the Gallegos-Rosenthal Patient Advocate Program, to represent the interests of enrollees served by health care service plans regulated by the department. The goal of the office shall be to help enrollees secure health care services to which they are entitled under the laws administered by the department.

(2) The office shall be headed by a patient advocate recommended to the Governor by the Secretary of the Business, Transportation and Housing Agency. The patient advocate shall be appointed by and serve at the pleasure of the Governor.

(3) The duties of the office shall be determined by the secretary, in consultation with the director, and shall include, but not be limited to:

(A) Developing educational and informational guides for consumers describing enrollee rights and responsibilities, and informing enrollees on effective ways to exercise their rights to secure health care services. The guides shall be easy to read and understand, available in English and other languages, and shall be made available to the public by the department, including access on the department's Internet website and through public outreach and educational programs.

(B) Compiling an annual publication, to be made available on the department's Internet website, of a quality of care report card including but not limited to health care service plans.

(C) Rendering advice and assistance to enrollees regarding procedures, rights, and responsibilities related to the use of health care service plan grievance systems, the department's system for reviewing unresolved grievances, and the independent review process.

(D) Making referrals within the department regarding studies, investigations, audits, or enforcement that may be appropriate to protect the interests of enrollees.

(E) Coordinating and working with other government and nongovernment patient assistance programs and health care ombudsprograms.

(4) The director, in consultation with the patient advocate, shall provide for the assignment of personnel to the office. The department may employ or contract with experts when necessary to carry out functions of the office. The annual budget for the office shall be separately identified in the annual budget request of the department.

(5) The office shall have access to department records including, but not limited to, information related to health care service plan audits, surveys, and enrollee grievances. The department shall assist the office in compelling the production and disclosure of any information the office deems necessary to perform its duties, from entities regulated by the department, if the information is determined by the department's legal counsel to be subject, under existing law, to production or disclosure to the department.

(6) The patient advocate shall annually issue a public report on the activities of the office, and shall appear before the appropriate policy and fiscal committees of the Senate and Assembly, if requested, to report and make recommendations on the activities of the office.

SEC. 35. Section 1368.2 of the Health and Safety Code is amended to read:

1368.2. (a) On and after January 1, 2002, every group health care service plan contract, except a specialized health care service plan contract, which is issued, amended, or renewed, shall include a provision for hospice care.

(b) The hospice care shall at a minimum be equivalent to hospice care provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act.

(c) The following are applicable to this section and to paragraph (7) of subdivision (b) of Section 1345:

(1) The definitions in Section 1746.

(2) The ''federal regulations'' which means the regulations adopted for hospice care under Title XVIII of the Social Security Act in Title 42 of the Code of Federal Regulations, Chapter IV, Part 418, except Subparts A, B, G, and H, and any amendments or successor provisions thereto.

(d) The director no later than January 1, 2001, shall adopt regulations to implement this section. The regulations shall meet all of the following requirements:

(1) Be consistent with all material elements of the federal regulations that are not by their terms applicable only to eligible Medicare beneficiaries. If there is a conflict between a federal regulation and any state regulation, other than those adopted pursuant to this section, the director shall adopt the regulation that is most favorable for plan subscribers, members or enrollees to receive hospice care.

(2) Be consistent with any other applicable federal or state laws.

(3) Be consistent with the definitions of Section 1746.

(e) This section is not applicable to the subscribers, members, or enrollees of a health care service plan who elect to receive hospice care under the Medicare program.

(f) The director, commencing on January 15, 2002, and on each January 15th thereafter, shall report to the Advisory Committee on Managed Health Care any changes in the federal regulations that differ materially from the regulations then in effect for this section. The director shall include with the report written text for proposed changes to the regulations then in effect for this section needed to meet the requirements of subdivision (d).

SEC. 36. Section 1371.4 of the Health and Safety Code is amended to read:

1371.4. (a) A health care service plan, or its contracting medical providers, shall provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior

authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when

an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(i) The definitions set forth in Section 1317.1 shall control the construction of this section.

SEC. 37. Section 1373.95 of the Health and Safety Code is amended to read:

1373.95. (a) On or before July 1, 1996, every health care service plan that provides coverage on a group basis shall file with the Department of Managed Health Care, a written policy describing how the health plan shall facilitate the continuity of care for new enrollees receiving services during a current episode of care for an acute condition from a nonparticipating provider. This written policy shall describe the process used to facilitate the continuity of care, including the assumption of care by a participating provider. Notice of the policy and information regarding how enrollees may request a review under the policy shall be provided to all new enrollees, except those enrollees who are not eligible as described in subdivision (e). A copy of the written policy shall be provided to eligible enrollees upon request.

(b) The written policy shall describe how requests to continue services with an existing provider are reviewed by the plan. The policy shall ensure that reasonable consideration is given to the potential clinical effect that a change of provider would have on the enrollee's treatment for the acute condition.

(c) A health care service plan may require any nonparticipating provider whose services are continued pursuant to the written policy to agree in writing to meet the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment. If the health care service plan determines that a patient's health care treatment should temporarily continue with the patient's existing provider, the health care service plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider.

(d) Nothing in this section shall require a health care service plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

(e) The written policy shall not apply to any enrollee who is offered an out-of-network option, or who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

(f) This section shall not apply to health plan contracts that include out-of-network coverage under which the enrollee is able to obtain services from the enrollee's existing provider.

(g) For purposes of this section, ''provider'' refers to a person who is described in subdivision (f) of Section 900 of the Business and Professions Code.

SEC. 38. Section 1374.30 of the Health and Safety Code is amended to read:

1374.30. (a) Commencing January 1, 2001, there is hereby established in the department the Independent Medical Review System.

(b) For the purposes of this chapter, ''disputed health care service'' means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. A disputed health care service does not include services provided by a specialized health care service plan, except to the extent that the service (1) involves the practice of medicine, or (2) is provided pursuant to a contract with a health care service plan that covers hospital, medical, or surgical benefits. If a plan, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the statement of decision shall clearly specify the provision in the contract that excludes that coverage.

(c) For the purposes of this chapter, ''coverage decision'' means the approval or denial of health care services by a plan, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract. A ''coverage decision'' does not encompass a plan or contracting provider decision regarding a disputed health care service.

(d) (1) All enrollee grievances involving a disputed health care service are eligible for review under the Independent Medical Review System if the requirements of this article are met. If the department finds that an enrollee grievance involving a disputed health care service does not meet the requirements of this article for review under the Independent Medical Review System, the enrollee

request for review shall be treated as a request for the department to review the grievance pursuant to subdivision (b) of Section 1368. All other enrollee grievances, including grievances involving coverage decisions, remain eligible for review by the department pursuant to subdivision (b) of Section 1368.

(2) In any case in which an enrollee or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this article or pursuant to subdivision (b) of Section 1368.

(3) The department shall be the final arbiter when there is a question as to whether an enrollee grievance is a disputed health care service or a coverage decision. The department shall establish a process to complete an initial screening of an enrollee grievance. If there appears to be any medical necessity issue, the grievance shall be resolved pursuant to an independent medical review as provided under this article or pursuant to subdivision (b) of Section 1368.

(e) Every health care service plan contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall, effective January 1, 2001, provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the plan, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. For purposes of this article, an enrollee may designate an agent to act on his or her behalf, as described in paragraph (2) of subdivision (b) of Section 1368. The provider may join with or otherwise assist the enrollee in seeking an independent medical review, and may advocate on behalf of the enrollee.

(f) Medi-Cal beneficiaries enrolled in a health care service plan shall not be excluded from participation. Medicare beneficiaries enrolled in a health care service plan shall not be excluded unless expressly preempted by federal law. Reviews of cases for Medi-Cal enrollees shall be conducted in accordance with statutes and regulations for the Medi-Cal program.

(g) The department may seek to integrate the quality of care and consumer protection provisions, including remedies, of the Independent Medical Review System with related dispute resolution procedures of other health care agency programs, including the Medicare and Medi-Cal programs, in a way that minimizes the potential for duplication, conflict, and added costs. Nothing in this subdivision shall be construed to limit any rights conferred upon enrollees under this chapter.

(h) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available.

(i) No later than January 1, 2001, every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers.

(j) An enrollee may apply to the department for an independent medical review when all of the following conditions are met:

(1) (A) The enrollee's provider has recommended a health care service as medically necessary, or

(B) The enrollee has received urgent care or emergency services that a provider determined was medically necessary, or

(C) The enrollee, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The plan shall expedite access to an in-plan provider upon request of an enrollee. The in-plan provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review.

For purposes of this article, the enrollee's provider may be an out-of-plan provider. However, the plan shall have no liability for payment of services provided by an out-of-plan provider, except as provided pursuant to subdivision (c) of Section 1374.34.

(2) The disputed health care service has been denied, modified, or delayed by the plan, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.

(3) The enrollee has filed a grievance with the plan or its contracting provider pursuant to Section 1368, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The enrollee shall not be required to participate in the plan's grievance process for more than 30 days. In the case of a grievance that requires expedited review pursuant to Section 1368.01, the enrollee shall not be required to participate in the plan's grievance process for more than three days.

(k) An enrollee may apply to the department for an independent medical review of a decision to deny, modify, or delay health care

services, based in whole or in part on a finding that the disputed health care services are not medically necessary, within six months of any of the qualifying periods or events under subdivision (j). The director may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

(*l*) The enrollee shall pay no application or processing fees of any kind.

(m) As part of its notification to the enrollee regarding a disposition of the enrollee's grievance that denies, modifies, or delays health care services, the plan shall provide the enrollee with a one-page application form approved by the department, and an addressed envelope, which the enrollee may return to initiate an independent medical review. The plan shall include on the form any information required by the department to facilitate the completion of the independent medical review, such as the enrollee's diagnosis or condition, the nature of the disputed health care service sought by the enrollee, a means to identify the enrollee's case, and any other material information. The form shall also include the following:

(1) Notice that a decision not to participate in the independent medical review process may cause the enrollee to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.

(2) A statement indicating the enrollee's consent to obtain any necessary medical records from the plan, any of its contracting providers, and any out-of-plan provider the enrollee may have consulted on the matter, to be signed by the enrollee.

(3) Notice of the enrollee's right to provide information or documentation, either directly or through the enrollee's provider, regarding any of the following:

(A) A provider recommendation indicating that the disputed health care service is medically necessary for the enrollee's medical condition.

(B) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the enrollee's medical condition.

(C) Reasonable information supporting the enrollee's position that the disputed health care service is or was medically necessary for the enrollee's medical condition, including all information provided to the enrollee by the plan or any of its contracting providers, still in the possession of the enrollee, concerning a plan or provider decision regarding disputed health care services, and a copy of any materials the enrollee submitted to the plan, still in the possession of the enrollee, in support of the grievance, as well as any additional material that the enrollee believes is relevant.

(n) Upon notice from the department that the health care service plan's enrollee has applied for an independent medical review, the plan or its contracting providers shall provide to the independent

medical review organization designated by the department a copy of all of the following documents within three business days of the plan's receipt of the department's notice of a request by an enrollee for an independent review:

(1) (A) A copy of all of the enrollee's medical records in the possession of the plan or its contracting providers relevant to each of the following:

(i) The enrollee's medical condition.

(ii) The health care services being provided by the plan and its contracting providers for the condition.

(iii) The disputed health care services requested by the enrollee for the condition.

(B) Any newly developed or discovered relevant medical records in the possession of the plan or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The plan shall concurrently provide a copy of medical records required by this subparagraph to the enrollee or the enrollee's provider, if authorized by the enrollee, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(2) A copy of all information provided to the enrollee by the plan and any of its contracting providers concerning plan and provider decisions regarding the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's provider submitted to the plan and to the plan's contracting providers in support of the enrollee's request for disputed health care services. This documentation shall include the written response to the enrollee's grievance, required by paragraph (4) of subdivision (a) of Section 1368. The confidentiality of any enrollee medical information shall be maintained pursuant to applicable state and federal laws.

(3) A copy of any other relevant documents or information used by the plan or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the plan and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The plan shall concurrently provide a copy of documents required by this paragraph, except for any information found by the director to be legally privileged information, to the enrollee and the enrollee's provider. The department and the independent review organization shall maintain the confidentiality of any information found by the director to be the proprietary information of the plan.

SEC. 39. Section 1374.32 of the Health and Safety Code is amended to read:

1374.32. (a) By January 1, 2001, the department shall contract with one or more independent medical review organizations in the state to conduct reviews for purposes of this article. The independent medical review organizations shall be independent of any health care service plan doing business in this state. The director may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, that an organization shall be required to meet in order to qualify for participation in the Independent Medical Review System and to assist the department in carrying out its responsibilities.

(b) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be medical consultants for purposes of Section 43.98 of the Civil Code.

(c) The independent medical review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent medical review organization shall not have any material professional, familial, or financial affiliation, as determined by the director, with any of the following:

(1) The plan.

(2) Any officer, director, or employee of the plan.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the plan, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the enrollee whose treatment is under review, or the alternative therapy, if any, recommended by the plan.

(6) The enrollee or the enrollee's immediate family.

(d) In order to contract with the department for purposes of this article, an independent medical review organization shall meet all of the following requirements:

(1) The organization shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a health plan or a trade association of health plans. A board member, director, officer, or employee of the independent medical review organization shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health plan or a trade association of health plans shall not serve as a board member, director, officer, or employee of an independent medical review organization.

(2) The organization shall submit to the department the following information upon initial application to contract for purposes of this

article and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars ($100,000), if any.

(C) The names of all corporations and organizations that the independent medical review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the independent medical review organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care organization, provider group, or board or committee of a plan, managed care organization, or provider group.

(E) (i) The percentage of revenue the independent medical review organization receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, and utilization reviews.

(ii) The names of any health care service plan or provider group for which the independent medical review organization provides review services, including, but not limited to, utilization review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.

(F) A description of the review process including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(G) A description of the system the independent medical review organization uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise that the medical professionals are credentialed to review.

(H) A description of how the independent medical review organization ensures compliance with the conflict-of-interest provisions of this section.

(3) The organization shall demonstrate that it has a quality assurance mechanism in place that does the following:

(A) Ensures that the medical professionals retained are appropriately credentialed and privileged.

(B) Ensures that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts-of-interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent medical review organizations to review medical treatment decisions shall be physicians or other appropriate providers who meet the following minimum requirements:

(A) The medical professional shall be a clinician knowledgeable in the treatment of the enrollee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) Notwithstanding any other provision of law, the medical professional shall hold a nonrestricted license in any state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. The independent medical review organization shall give preference to the use of a physician licensed in California as the reviewer, except when training and experience with the issue under review reasonably requires the use of an out-of-state reviewer.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(5) Neither the expert reviewer, nor the independent medical review organization, shall have any material professional, material familial, or material financial affiliation with any of the following:

(A) The plan or a provider group of the plan, except that an academic medical center under contract to the plan to provide services to enrollees may qualify as an independent medical review organization provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the plan.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the enrollee whose condition is under review.

(F) The enrollee or the enrollee's immediate family.

(6) For purposes of this section, the following terms shall have the following meanings:

(A) ''Material familial affiliation'' means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(B) ''Material professional affiliation'' means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent medical review organization. ''Material professional affiliation'' does not include affiliations that are limited to staff privileges at a health facility.

(C) ''Material financial affiliation'' means any financial interest of more than 5 percent of total annual revenue or total annual income of an independent medical review organization or individual to which this subdivision applies. ''Material financial affiliation'' does not include payment by the plan to the independent medical review organization for the services required by this section, nor does ''material financial affiliation'' include an expert's participation as a contracting plan provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(e) The department shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the director, filed with it by an independent medical review organization seeking to contract under this article. The department may charge a nominal fee to the interested person for photocopying the requested information.

SEC. 40. Section 1374.9 of the Health and Safety Code is amended to read:

1374.9. For violations of Section 1374.7, the commissioner may, after appropriate notice and opportunity for hearing, by order levy administrative penalties as follows:

(a) Any health care service plan that violates Section 1374.7, or that violates any rule or order adopted or issued pursuant to this section, is liable for administrative penalties of not less than two thousand five hundred dollars ($2,500) for each first violation, and of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000) for each second violation, and of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each subsequent violation.

(b) The administrative penalties shall be paid to the Managed Health Care Fund.

(c) The administrative penalties available to the commissioner pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the commissioner to enforce the provisions of this chapter.

SEC. 41. Section 1380 of the Health and Safety Code is amended to read:

1380. (a) The department shall conduct periodically an onsite medical survey of the health delivery system of each plan. The survey shall include a review of the procedures for obtaining health services, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees.

(b) The survey shall be conducted by a panel of qualified health professionals experienced in evaluating the delivery of prepaid health care. The department shall be authorized to contract with professional organizations or outside personnel to conduct medical surveys and these contracts shall be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. These organizations or personnel shall have demonstrated the ability to objectively evaluate the delivery of health care by plans or health maintenance organizations.

(c) Surveys performed pursuant to this section shall be conducted as often as deemed necessary by the director to assure the protection of subscribers and enrollees, but not less frequently than once every three years. Nothing in this section shall be construed to require the survey team to visit each clinic, hospital office, or facility of the plan. To avoid duplication, the director shall employ, but is not bound by, the following:

(1) For hospital-based health care service plans, to the extent necessary to satisfy the requirements of this section, the findings of inspections conducted pursuant to Section 1279.

(2) For health care service plans contracting with the State Department of Health Services pursuant to the Waxman-Duffy Prepaid Health Plan Act, the findings of reviews conducted pursuant to Section 14456 of the Welfare and Institutions Code.

(3) To the extent feasible, reviews of providers conducted by professional standards review organizations, and surveys and audits conducted by other governmental entities.

(d) Nothing in this section shall be construed to require the medical survey team to review peer review proceedings and records conducted and compiled under Section 1370 or medical records. However, the director shall be authorized to require onsite review of these peer review proceedings and records or medical records where necessary to determine that quality health care is being

delivered to subscribers and enrollees. Where medical record review is authorized, the survey team shall insure that the confidentiality of physician-patient relationship is safeguarded in accordance with existing law and neither the survey team nor the director or the director's staff may be compelled to disclose this information except in accordance with the physician-patient relationship. The director shall ensure that the confidentiality of the peer review proceedings and records is maintained. The disclosure of the peer review proceedings and records to the director or the medical survey team shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to Sections 1370 and 1370.1.

(e) The procedures and standards utilized by the survey team shall be made available to the plans prior to the conducting of medical surveys.

(f) During the survey the members of the survey team shall examine the complaint files kept by the plan pursuant to Section 1368. The survey report issued pursuant to subdivision (i) shall include a discussion of the plan's record for handling complaints.

(g) During the survey the members of the survey team shall offer such advice and assistance to the plan as deemed appropriate.

(h) (1) Survey results shall be publicly reported by the director as quickly as possible but no later than 180 days following the completion of the survey unless the director determines, in his or her discretion, that additional time is reasonably necessary to fully and fairly report the survey results. The director shall provide the plan with an overview of survey findings and notify the plan of deficiencies found by the survey team at least 90 days prior to the release of the public report.

(2) Reports on all surveys, deficiencies, and correction plans shall be open to public inspection except that no surveys, deficiencies, or correction plans shall be made public unless the plan has had an opportunity to review the report and file a response within 45 days of the date that the department provided the report to the plan. After reviewing the plan's response, the director shall issue a final report that excludes any survey information and legal findings and conclusions determined by the director to be in error, describes compliance efforts, identifies deficiencies that have been corrected by the plan by the time of the director's receipt of the plan's 45-day response, and describes remedial actions for deficiencies requiring longer periods to the remedy required by the director or proposed by the plan.

(3) The final report shall not include a description of ''acceptable'' or of ''compliance'' for any uncorrected deficiency.

(4) Upon making the final report available to the public, a single copy of a summary of the final report's findings shall be made available free of charge by the department to members of the public,

upon request. Additional copies of the summary may be provided at the department's cost. The summary shall include a discussion of compliance efforts, corrected deficiencies, and proposed remedial actions.

(5) If requested by the plan, the director shall append the plan's response to the final report issued pursuant to paragraph (2), and shall append to the summary issued pursuant to paragraph (4) a brief statement provided by the plan summarizing its response to the report. The plan may modify its response or statement at any time and provide modified copies to the department for public distribution no later than 10 days from the date of notification from the department that the final report will be made available to the public. The plan may file an addendum to its response or statement at any time after the final report has been made available to the public. The addendum to the response or statement shall also be made available to the public.

(6) Any information determined by the director to be confidential pursuant to statutes relating to the disclosure of records, including the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), shall not be made public.

(i) (1) The director shall give the plan a reasonable time to correct deficiencies. Failure on the part of the plan to comply to the director's satisfaction shall constitute cause for disciplinary action against the plan.

(2) No later than 18 months following release of the final report required by subdivision (h), the department shall conduct a follow-up review to determine and report on the status of the plan's efforts to correct deficiencies. The department's follow-up report shall identify any deficiencies reported pursuant to subdivision (h) that have not been corrected to the satisfaction of the director.

(3) If requested by the plan, the director shall append the plan's response to the follow-up report issued pursuant to paragraph (2). The plan may modify its response at any time and provide modified copies to the department for public distribution no later than 10 days from the date of notification from the department that the follow-up report will be made available to the public. The plan may file an addendum to its response at any time after the follow-up report has been made available to the public. The addendum to the response or statement shall also be made available to the public.

(j) The director shall provide to the plan and to the executive officer of the Board of Dental Examiners a copy of information relating to the quality of care of any licensed dental provider contained in any report described in subdivisions (h) and (i) that, in the judgment of the director, indicates clearly excessive treatment, incompetent treatment, grossly negligent treatment, repeated negligent acts, or unnecessary treatment. Any confidential

information provided by the director shall not be made public pursuant to this subdivision. Notwithstanding any other provision of law, the disclosure of this information to the plan and to the executive officer shall not operate as a waiver of confidentiality. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the State of California, the Department of Managed Health Care, the Director of the Department of Managed Health Care, the Board of Dental Examiners, or any officer, agent, employee, consultant, or contractor of the state or the department or the board for the release of any false or unauthorized information pursuant to this section, unless the release of that information is made with knowledge and malice.

(k) Nothing in this section shall be construed as affecting the director's authority pursuant to Article 7 (commencing with Section 1386) or Article 8 (commencing with Section 1390) of this chapter.

SEC. 42. Section 1380.1 of the Health and Safety Code is amended to read:

1380.1. (a) (1) With the department as the lead agency, the department and the State Department of Health Services shall convene a working group for the purpose of developing standards for quality audits of providers that provide services to enrollees pursuant to contracts governed by this chapter.

(2) The working group shall include, but not be limited to, representatives of health care service plans, consumer organizations, public and private purchasers of health care, and providers, including medical groups, independent practice associations, and health facilities.

(3) The working group shall be comprised so that a balance of perspectives of providers, plans, purchasers of health care, and consumers can reasonably be expected to be represented.

(4) The department may consult with the National Commission on Quality Assurance, the federal Health Care Financing Authority, and other organizations that have worked toward defining quality standards.

(5) The department shall consult with the State Department of Health Services on the implementation of this section.

(6) The Legislature recognizes that streamlining audits, and defining quality standards, are best achieved with consideration of federal regulatory and third party auditing standards.

(b) To the extent feasible, the goals of this working group shall include, but not be limited to, all of the following:

(1) Recommending ways to reduce duplicative audits of providers by health plans.

(2) Developing a core set of health care quality standards that can serve as baseline requirements for meeting audit standards for contracts governed by this chapter.

(3) Recommending data collection methods and processes that can result in better coordination of health care quality audits, lessen the burden on providers, and maintain high quality standards for providers.

(4) Developing recommendations as to how health care service plans can best access quality information about providers in order to ensure higher quality standards than those core standards identified by the working group.

(5) Recommending standards for determining appropriate nonprofit organizations to conduct audits pursuant to the standards developed in this section.

(6) Determining how the results of quality audits shall be made available to the public.

(c) The department shall report to the Governor, the Department of Managed Health Care, the State Department of Health Services, and the appropriate committees of the Legislature, on or before January 1, 2000, its findings and recommendations pursuant to this section.

SEC. 43. Section 1383.15 of the Health and Safety Code is amended to read:

1383.15. (a) When requested by an enrollee or participating health professional who is treating an enrollee, a health care service plan shall provide or authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If the enrollee questions the reasonableness or necessity of recommended surgical procedures.

(2) If the enrollee questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis.

(4) If the treatment plan in progress is not improving the medical condition of the enrollee within an appropriate period of time given the diagnosis and plan of care, and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment.

(5) If the enrollee has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

(b) For purposes of this section, an appropriately qualified health care professional is a primary care physician, specialist, or other licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training

and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion. For purposes of a specialized health care service plan, an appropriately qualified health care professional is a licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

(c) If an enrollee or participating health professional who is treating an enrollee requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the enrollee's ability to regain maximum function, the second opinion shall be authorized or denied in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the request, whenever possible. Each plan shall file with the Department of Managed Health Care timelines for responding to requests for second opinions for cases involving emergency needs, urgent care, and other requests by July 1, 2000, and within 30 days of any amendment to the timelines. The timelines shall be made available to the public upon request.

(d) If a health care service plan approves a request by an enrollee for a second opinion, the enrollee shall be responsible only for the costs of applicable copayments that the plan requires for similar referrals.

(e) If the enrollee is requesting a second opinion about care from his or her primary care physician, the second opinion shall be provided by an appropriately qualified health care professional of the enrollee's choice within the same physician organization.

(f) If the enrollee is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of the enrollee's choice from any independent practice association or medical group within the network of the same or equivalent specialty. If the specialist is not within the same physician organization, the plan shall incur the cost or negotiate the fee arrangements of that second opinion, beyond the applicable copayments which shall be paid by the enrollee. If not authorized by the plan, additional medical opinions not within the original physician organization shall be the responsibility of the enrollee.

(g) If there is no participating plan provider within the network who meets the standard specified in subdivision (b), then the plan shall authorize a second opinion by an appropriately qualified health professional outside of the plan's provider network. In approving a second opinion either inside or outside of the plan's provider

network, the plan shall take into account the ability of the enrollee to travel to the provider.

(h) The health care service plan shall require the second opinion health professional to provide the enrollee and the initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate. Nothing in this section shall be construed to prevent the plan from authorizing, based on its independent determination, additional medical opinions concerning the medical condition of an enrollee.

(i) If the health care service plan denies a request by an enrollee for a second opinion, it shall notify the enrollee in writing of the reasons for the denial and shall inform the enrollee of the right to file a grievance with the plan. The notice shall comply with subdivision (b) of Section 1368.02.

(j) Unless authorized by the plan, in order for services to be covered the enrollee shall obtain services only from a provider who is participating in, or under contract with, the plan pursuant to the specific contract under which the enrollee is entitled to health care services. The plan may limit referrals to its network of providers if there is a participating plan provider who meets the standard specified in subdivision (b).

(k) This section shall not apply to health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements if, subject to all other terms and conditions of the contract that apply generally to all other benefits, access to and coverage for second opinions are not limited.

SEC. 44. Section 1391.5 of the Health and Safety Code is amended to read:

1391.5. (a) If, after examination or investigation, the director has reasonable grounds to believe that irreparable loss and injury to the plan's enrollee or enrollees occurred or may occur as a result of any act or practice unless the director acts immediately, the director may, by written order, addressed to that person, order the discontinuance of the unsafe or injurious act or practice. The order shall become effective immediately, but shall not become final except in accordance with this section.

(b) No order issued pursuant to this section shall become final except after notice to the affected person of the director's intention to make the order final and of the reasons for the finding. The director shall also notify that person that upon receiving a request for hearing by the plan, the matter shall be set for hearing to commence with 15 business days after receipt of the request, unless that person consents to have the hearing commence at a later date.

(c) If no hearing is requested within 15 days after the mailing or service of the required notice, and none is ordered by the director, the order shall become final on the 15th day without a hearing and

shall not be subject to review by any court or agency notwithstanding subdivision (b) of Section 1397.

(d) If a hearing is requested or ordered, it shall be held in accordance with the provisions of the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and the director shall have all of the powers granted under that act.

(e) If, upon conclusion of the hearing, it appears to the director that the affected person has conducted business in an unsafe or injurious manner, the director shall make the order of discontinuance final.

(f) For purposes of this section, ''person'' includes any plan, solicitor firm, or any representative thereof, a solicitor, or any other person defined in subdivision (j) of Section 1345.

SEC. 45. Section 1393.6 of the Health and Safety Code is amended to read:

1393.6. For violations of Article 3.1 (commencing with Section 1357) and Article 3.15 (commencing with Section 1357.50), the director may, after appropriate notice and opportunity for hearing, by order levy administrative penalties as follows:

(a) Any person, solicitor, or solicitor firm, other than a health care service plan, who willfully violates any provision of this chapter, or who willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two hundred fifty dollars ($250) for each first violation, and of not less than one thousand dollars ($1,000) and not more than two thousand five hundred dollars ($2,500) for each subsequent violation.

(b) Any health care service plan that willfully violates any provision of this chapter, or that willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two thousand five hundred dollars ($2,500) for each first violation, and of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000) for each second violation, and of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each subsequent violation.

(c) The administrative penalties shall be paid to the Managed Health Care Fund.

(d) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

SEC. 46. Section 1397.5 of the Health and Safety Code is amended to read:

1397.5. (a) The director shall make and file annually with the Department of Managed Health Care as a public record, an

aggregate summary of grievances against plans filed with the director by enrollees or subscribers. This summary shall include at least all of the following information:

(1) The total number of grievances filed.

(2) The types of grievances.

(b) The summary set forth in subdivision (a) shall include the following disclaimer:

THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

(c) Nothing in this section shall require or authorize the disclosure of grievances filed with or received by the director and made confidential pursuant to any other provision of law including, but not limited to, the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). Nothing in this section shall affect any other provision of law including, but not limited to, the California Public Records Act and the Information Practices Act of 1977.

SEC. 47. Section 1398 of the Health and Safety Code is repealed.

SEC. 48. Section 11758.47 of the Health and Safety Code is amended to read:

11758.47. Service providers may assist Medi-Cal beneficiaries, upon request, to file a fair hearing request in accordance with Chapter 7 (commencing with Section 10950) of Part 2 of Division 9 of the Welfare and Institutions Code, or may inform Medi-Cal beneficiaries about the Department of Managed Health Care's toll-free telephone number for health care service plan members or the State Department of Health Services' ombudsman for Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans.

SEC. 49. Section 32121 of the Health and Safety Code is amended to read:

32121. Each local district shall have and may exercise the following powers:

(a) To have and use a corporate seal and alter it at its pleasure.

(b) To sue and be sued in all courts and places and in all actions and proceedings whatever.

(c) To purchase, receive, have, take, hold, lease, use, and enjoy property of every kind and description within and without the limits of the district, and to control, dispose of, convey, and encumber the same and create a leasehold interest in the same for the benefit of the district.

(d) To exercise the right of eminent domain for the purpose of acquiring real or personal property of every kind necessary to the exercise of any of the powers of the district.

(e) To establish one or more trusts for the benefit of the district, to administer any trust declared or created for the benefit of the district, to designate one or more trustees for trusts created by the district, to receive by gift, devise, or bequest, and hold in trust or otherwise, property, including corporate securities of all kinds, situated in this state or elsewhere, and where not otherwise provided, dispose of the same for the benefit of the district.

(f) To employ legal counsel to advise the board of directors in all matters pertaining to the business of the district, to perform the functions in respect to the legal affairs of the district as the board may direct, and to call upon the district attorney of the county in which the greater part of the land in the district is situated for legal advice and assistance in all matters concerning the district, except that if that county has a county counsel, the directors may call upon the county counsel for legal advice and assistance.

(g) To employ any officers and employees, including architects and consultants, the board of directors deems necessary to carry on properly the business of the district.

(h) To prescribe the duties and powers of the health care facility administrator, secretary, and other officers and employees of any health care facilities of the district, to establish offices as may be appropriate and to appoint board members or employees to those offices, and to determine the number of, and appoint, all officers and employees and to fix their compensation. The officers and employees shall hold their offices or positions at the pleasure of the boards of directors.

(i) To do any and all things that an individual might do that are necessary for, and to the advantage of, a health care facility and a nurses' training school, or a child care facility for the benefit of employees of the health care facility or residents of the district.

(j) To establish, maintain, and operate, or provide assistance in the operation of, one or more health facilities or health services, including, but not limited to, outpatient programs, services, and facilities, retirement programs, services, and facilities, chemical dependency programs, services, and facilities, or other health care programs, services, and facilities and activities at any location within or without the district for the benefit of the district and the people served by the district.

''Health care facilities,'' as used in this subdivision, means those facilities defined in subdivision (b) of Section 32000.1 and specifically includes freestanding chemical dependency recovery units. ''Health facilities,'' as used in this subdivision, may also include those facilities defined in subdivision (d) of Section 15432 of the Government Code.

(k) To do any and all other acts and things necessary to carry out this division.

(*l*) To acquire, maintain, and operate ambulances or ambulance services within and without the district.

(m) To establish, maintain, and operate, or provide assistance in the operation of, free clinics, diagnostic and testing centers, health education programs, wellness and prevention programs, rehabilitation, aftercare, and any other health care services provider, groups, and organizations that are necessary for the maintenance of good physical and mental health in the communities served by the district.

(n) To establish and operate in cooperation with its medical staff a coinsurance plan between the hospital district and the members of its attending medical staff.

(o) To establish, maintain, and carry on its activities through one or more corporations, joint ventures, or partnerships for the benefit of the health care district.

(p) (1) To transfer, at fair market value, any part of its assets to one or more nonprofit corporations to operate and maintain the assets. A transfer pursuant to this paragraph shall be deemed to be at fair market value if an independent consultant, with expertise in methods of appraisal and valuation and in accordance with applicable governmental and industry standards for appraisal and valuation, determines that fair and reasonable consideration is to be received by the district for the transferred district assets. Before the district transfers, pursuant to this paragraph, 50 percent or more of the district's assets to one or more nonprofit corporations, in sum or by increment, the elected board shall, by resolution, submit to the voters of the district a measure proposing the transfer. The measure shall be placed on the ballot of a special election held upon the request of the district or the ballot of the next regularly scheduled election occurring at least 88 days after the resolution of the board. If a majority of the voters voting on the measure vote in its favor, the transfer shall be approved. The campaign disclosure requirements applicable to local measures provided under Chapter 4 (commencing with Section 84100) of Title 9 of the Government Code shall apply to this election.

(2) To transfer, for the benefit of the communities served by the district, in the absence of adequate consideration, any part of the assets of the district, including without limitation real property, equipment, and other fixed assets, current assets, and cash, relating to the operation of the district's health care facilities to one or more nonprofit corporations to operate and maintain the assets.

(A) A transfer of 50 percent or more of the district's assets, in sum or by increment, pursuant to this paragraph shall be deemed to be for the benefit of the communities served by the district only if all of the following occur:

(i) The transfer agreement and all arrangements necessary thereto are fully discussed in advance of the district board decision to transfer the assets of the district in at least five properly noticed open and public meetings in compliance with the Ralph M. Brown Act, Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code, and Section 32106.

(ii) The transfer agreement provides that the hospital district shall approve all initial board members of the nonprofit corporation and any subsequent board members as may be specified in the transfer agreement.

(iii) The transfer agreement provides that all assets transferred to the nonprofit corporation, and all assets accumulated by the corporation during the term of the transfer agreement arising out of or from the operation of the transferred assets, are to be transferred back to the district upon termination of the transfer agreement, including any extension of the transfer agreement.

(iv) The transfer agreement commits the nonprofit corporation to operate and maintain the district's health care facilities and its assets for the benefit of the communities served by the district.

(v) The transfer agreement requires that any funds received from the district at the outset of the agreement or any time thereafter during the term of the agreement be used only to reduce district indebtedness, to acquire needed equipment for the district health care facilities, to operate, maintain, and make needed capital improvements to the district's health care facilities, to provide supplemental health care services or facilities for the communities served by the district, or to conduct other activities that would further a valid public purpose if undertaken directly by the district.

(B) A transfer of 33 percent or more but less than 50 percent of the district's assets, in sum or by increment, pursuant to this paragraph shall be deemed to be for the benefit of the communities served by the district only if both of the following occur:

(i) The transfer agreement and all arrangements necessary thereto are fully discussed in advance of the district board decision to transfer the assets of the district in at least two properly noticed open and public meetings in compliance with the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), and Section 32106.

(ii) The transfer agreement meets all of the requirements of clauses (ii) to (v), inclusive, of subparagraph (A).

(C) A transfer of 10 percent or more but less than 33 percent of the district's assets, in sum or by increment, pursuant to this paragraph shall be deemed to be for the benefit of the communities served by the district only if both of the following occur:

(i) The transfer agreement and all arrangements necessary thereto are fully discussed in advance of the district board decision to transfer the assets of the district in at least two properly noticed

open and public meetings in compliance with the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), and Section 32106.

(ii) The transfer agreement meets all of the requirements of (iii) to (v), inclusive, of subparagraph (A).

(D) Before the district transfers, pursuant to this paragraph, 50 percent or more of the district's assets to one or more nonprofit corporations, in sum or by increment, the elected board shall, by resolution, submit to the voters of the district a measure proposing the transfer. The measure shall be placed on the ballot of a special election held upon the request of the district or the ballot of the next regularly scheduled election occurring at least 88 days after the resolution of the board. If a majority of the voters voting on the measure vote in its favor, the transfer shall be approved. The campaign disclosure requirements applicable to local measures provided under Chapter 4 (commencing with Section 84100) of Title 9 of the Government Code shall apply to this election.

(E) Notwithstanding the other provisions of this paragraph, a hospital district shall not transfer any portion of its assets to a private nonprofit organization that is owned or controlled by a religious creed, church, or sectarian denomination in the absence of adequate consideration.

(3) If the district board has previously transferred less than 50 percent of the district's assets pursuant to this subdivision, before any additional assets are transferred the board shall hold a public hearing and shall make a public determination that the additional assets to be transferred will not, in combination with any assets previously transferred, equal 50 percent or more of the total assets of the district.

(4) The amendments to this subdivision made during the 1991–92 Regular Session, and the amendments made to this subdivision and to Section 32126 made during the 1993–94 Regular Session, shall only apply to transfers made on or after the effective dates of the acts amending this subdivision. The amendments to this subdivision made during those sessions shall not apply to any of the following:

(A) A district that has discussed and adopted a board resolution, prior to September 1, 1992, that authorizes the development of a business plan for an integrated delivery system.

(B) A lease agreement, transfer agreement, or both between a district and a nonprofit corporation that were in full force and effect as of September 1, 1992, for as long as that lease agreement, transfer agreement, or both remain in full force and effect.

(5) Notwithstanding paragraph (4), if substantial amendments are proposed to be made to a transfer agreement described in subparagraph (A) or (B) of paragraph (4), the amendments shall be fully discussed in advance of the district board's decision to adopt the amendments in at least two properly noticed open and public meetings in compliance with Section 32106 and the Ralph M. Brown

Act, (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code).

(6) Notwithstanding paragraphs (4) and (5), a transfer agreement described in subparagraph (A) or (B) of paragraph (4) that provided for the transfer of less than 50 percent of a district's assets shall be subject to the requirements of subdivision (p) of Section 32121 when subsequent amendments to that transfer agreement would result in the transfer, in sum or by increment, of 50 percent or more of a district's assets to the nonprofit corporation.

(7) For purposes of this subdivision, a ''transfer'' means the transfer of ownership of the assets of a district. A lease of the real property or the tangible personal property of a district shall not be subject to this subdivision except as specified in Section 32121.4 and as required under Section 32126.

(8) Districts that request a special election pursuant to paragraph (1) or (2) shall reimburse counties for the costs of that special election as prescribed pursuant to Section 10520 of the Elections Code.

(9) Nothing in this section, including subdivision (j), shall be construed to permit a local district to obtain or be issued a single consolidated license to operate a separate physical plant as a skilled nursing facility or an intermediate care facility that is not located within the boundaries of the district.

(10) A transfer of any of the assets of a district to one or more nonprofit corporations to operate and maintain the assets shall not be required to meet paragraphs (1) to (9), inclusive, of this subdivision if all of the following conditions apply at the time of the transfer:

(A) The district has entered into a loan that is insured by the State of California under Chapter 1 (commencing with Section 129000) of Part 6 of Division 107.

(B) The district is in default of its loan obligations, as determined by the Office of Statewide Health Planning and Development.

(C) The Office of Statewide Health Planning and Development and the district, in their best judgment, agree the transfer of some or all of the assets of the district to a nonprofit corporation or corporations is necessary to cure the default, and will obviate the need for foreclosure. This cure of default provision shall be applicable prior to the office foreclosing on district hospital assets. After the office has foreclosed on district hospital assets, or otherwise taken possession in accordance with law, the office may exercise all of its powers to deal with and dispose of hospital property.

(D) The transfer and all arrangements necessary thereto are discussed in advance of the transfer in at least one properly noticed open and public meeting in compliance with the Ralph M. Brown Act, Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code and Section 32106. The meeting referred to in this paragraph shall be noticed and held within 90 days

of notice in writing to the district by the office of an event of default. If the meeting is not held within this 90-day period, the district shall be deemed to have waived this requirement to have a meeting.

(11) If a transfer under paragraph (10) is a lease, the lease shall provide that the assets shall revert to the district at the conclusion of the leasehold interest. If the transfer is a sale, the proceeds shall be used first to retire the obligation insured by the office, then to retire any other debts of the district. After providing for debts, any remaining funds shall revert to the district.

(q) To contract for bond insurance, letters of credit, remarketing services, and other forms of credit enhancement and liquidity support for its bonds, notes, and other indebtedness and to enter into reimbursement agreements, monitoring agreements, remarketing agreements, and similar ancillary contracts in connection therewith.

(r) To establish, maintain, operate, participate in, or manage capitated health care plans, health maintenance organizations, preferred provider organizations, and other managed health care systems and programs properly licensed by the Department of Insurance or the Department of Managed Health Care, at any location within or without the district for the benefit of residents of communities served by the district. However, that activity shall not be deemed to result in or constitute the giving or lending of the district's credit, assets, surpluses, cash, or tangible goods to, or in aid of, any person, association, or corporation in violation of Section 6 of Article XVI of the California Constitution.

Nothing in this section shall authorize activities that corporations and other artificial legal entities are prohibited from conducting by Section 2400 of the Business and Professions Code.

Any agreement to provide health care coverage that is a health care service plan, as defined in subdivision (f) of Section 1345, shall be subject to the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2, unless exempted pursuant to Section 1343 or 1349.2.

A district shall not provide health care coverage for any employee of an employer operating within the communities served by the district, unless the Legislature specifically authorizes, or has authorized in this section or elsewhere, the coverage.

This section shall not authorize any district to contribute its facilities to any joint venture that could result in transfer of the facilities from district ownership.

(s) To provide health care coverage to members of the district's medical staff, employees of the medical staff members, and the dependents of both groups, on a self-pay basis.

(t) This section shall become operative on January 1, 2001.

SEC. 50. Section 102910 of the Health and Safety Code is amended to read:

102910. For the purpose of conducting the three-year study required pursuant to Section 102905, the department is hereby encouraged to contract with a federally recognized tribe or tribal organization or an American Indian-controlled health care corporation or research institution having a record of good standing with the Department of Managed Health Care and the Indian Health program within the department, and established competence in the area of records management.

SEC. 51. Section 127580 of the Health and Safety Code is amended to read:

127580. The office, after consultation with the Insurance Commissioner, the Director of the Department of Managed Health Care, the State Director of Health Services, and the Director of Industrial Relations, shall adopt a California uniform billing form format for professional health care services and a California uniform billing form format for institutional provider services. The format for professional health care services shall be the format developed by the National Uniform Claim Form Task Force. The format for institutional provider services shall be the format developed by the National Uniform Billing Committee. The formats shall be acceptable for billing in federal Medicare and medicaid programs. The office shall specify a single uniform system for coding diagnoses, treatments, and procedures to be used as part of the uniform billing form formats. The system shall be acceptable for billing in federal Medicare and medicaid programs.

SEC. 52. Section 128725 of the Health and Safety Code is amended to read:

128725. The functions and duties of the commission shall include the following:

(a) Advise the office on the implementation of the new, consolidated data system.

(b) Advise the office regarding the ongoing need to collect and report health facility data and other provider data.

(c) Annually develop a report to the director of the office regarding changes that should be made to existing data collection systems and forms. Copies of the report shall be provided to the Senate Health and Human Services Committee and to the Assembly Health Committee.

(d) Advise the office regarding changes to the uniform accounting and reporting systems for health facilities.

(e) Conduct public meetings for the purposes of obtaining input from health facilities, other providers, data users, and the general public regarding this chapter and Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(f) Advise the Secretary of Health and Welfare on the formulation of general policies which shall advance the purposes of this part.

(g) Advise the office on the adoption, amendment, or repeal of regulations it proposes prior to their submittal to the Office of Administrative Law.

(h) Advise the office on the format of individual health facility or other provider data reports and on any technical and procedural issues necessary to implement this part.

(i) Advise the office on the formulation of general policies which shall advance the purposes of Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(j) Recommend, in consultation with a 12-member technical advisory committee appointed by the chairperson of the commission, to the office the data elements necessary for the production of outcome reports required by Section 128745.

(k) (1) The technical advisory committee appointed pursuant to subdivision (j) shall be composed of two members who shall be hospital representatives appointed from a list of at least six persons nominated by the California Association of Hospitals and Health Systems, two members who shall be physicians and surgeons appointed from a list of at least six persons nominated by the California Medical Association, two members who shall be registered nurses appointed from a list of at least six persons nominated by the California Nurses Association, one medical record practitioner who shall be appointed from a list of at least six persons nominated by the California Health Information Association, one member who shall be a representative of a hospital authorized to report as a group pursuant to subdivision (d) of Section 128760, two members who shall be representative of California research organizations experienced in effectiveness review of medical procedures or surgical procedures, or both procedures, one member representing the Health Access Foundation, and one member representing the Consumers Union. Members of the technical advisory committee shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the technical advisory committee.

(2) The commission shall submit its recommendation to the office regarding the first of the reports required pursuant to subdivision (a) of Section 128745 no later than January 1, 1993. The technical advisory committee shall submit its initial recommendations to the commission pursuant to subdivision (d) of Section 128750 no later than January 1, 1994. The commission, with the advice of the technical advisory committee, may periodically make additional recommendations under Sections 128745 and 128750 to the office, as appropriate.

(*l*) (1) Assess the value and usefulness of the reports required by Sections 127285, 128735, and 128740. On or before December 1, 1997, the commission shall submit recommendations to the office to accomplish all of the following:

(A) Eliminate redundant reporting.

(B) Eliminate collection of unnecessary data.

(C) Augment data bases as deemed valuable to enhance the quality and usefulness of data.

(D) Standardize data elements and definitions with other health data collection programs at both the state and national levels.

(E) Enable linkage with, and utilization of, existing data sets.

(F) Improve the methodology and data bases used for quality assessment analyses, including, but not limited to, risk-adjusted outcome reports.

(G) Improve the timeliness of reporting and public disclosure.

(2) The commission shall establish a committee to implement the evaluation process. The committee shall include representatives from the health care industry, providers, consumers, payers, purchasers, and government entities, including the Department of Managed Health Care, the departments that comprise the Health and Welfare Agency, and others deemed by the commission to be appropriate to the evaluation of the data bases. The committee may establish subcommittees including technical experts.

(3) In order to ensure the timely implementation of the provisions of the legislation enacted in the 1997–98 Regular Session that amended this part, the office shall present an implementation work plan to the commission. The work plan shall clearly define goals and significant steps within specified timeframes that must be completed in order to accomplish the purposes of that legislation. The office shall make periodic progress reports based on the work plan to the commission. The commission may advise the Secretary of Health and Welfare of any significant delays in following the work plan. If the commission determines that the office is not making significant progress toward achieving the goals outlined in the work plan, the commission shall notify the office and the secretary of that determination. The commission may request the office to submit a plan of correction outlining specific remedial actions and timeframes for compliance. Within 90 days of notification, the office shall submit a plan of correction to the commission.

(m) (1) As the office and the commission deem necessary, the commission may establish committees and appoint persons who are not members of the commission to these committees as are necessary to carry out the purposes of the commission. Representatives of area health planning agencies shall be invited, as appropriate, to serve on committees established by the office and the commission relative to the duties and responsibilities of area health planning agencies. Members of the standing committees shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of these committees.

(2) Whenever the office or the commission does not accept the advice of the other body on proposed regulations or on major policy issues, the office or the commission shall provide a written response on its action to the other body within 30 days, if so requested.

(3) The commission or the office director may appeal to the Secretary of Health and Welfare over disagreements on policy, procedural, or technical issues.

SEC. 53. Section 740 of the Insurance Code is amended to read:

740. (a) Notwithstanding any other provision of law, and except as provided herein, any person or other entity that provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the department unless the person or other entity shows that while providing the services it is subject to the jurisdiction of another agency of this or another state or the federal government.

(b) A person or entity may show that it is subject to the jurisdiction of another agency of this or another state or the federal government by providing to the commissioner the appropriate certificate or license issued by the other governmental agency that permits or qualifies it to provide those services for which it is licensed or certificated.

(c) Any person or entity that is unable to show that it is subject to the jurisdiction of another agency of this or another state or the federal government, shall submit to an examination by the commissioner to determine the organization and solvency of the person or the entity, and to determine whether the person or entity is in compliance with the applicable provisions of this code, and shall be required to obtain a certificate of authority to do business in California and be required to meet all appropriate reserve, surplus, capital, and other necessary requirements imposed by this code for all insurers.

(d) Any person or entity unable to show that it is subject to the jurisdiction of another agency of this or another state or the federal government shall be subject to all appropriate provisions of this code regarding the conduct of its business.

(e) The department shall prepare and maintain for public inspection a list of those persons or entities described in subdivision (a) that are not subject to the jurisdiction of another agency of this or another state or the federal government and that the department knows to be operating in this state. There shall be no liability of any kind on the part of the state, the department, and its employees for the accuracy of the list or for any comments made with respect to it.

(f) Any administrator licensed by the department who advertises or administers coverage in this state described in subdivision (a), that

is provided by any person or entity described in subdivision (c), and where the coverage does not meet all pertinent requirements specified in this code and that is not provided or completely underwritten, insured or otherwise fully covered by an admitted life or disability insurer, hospital service plan or health care service plan, shall advise and disclose to any purchaser, prospective purchaser, covered person or entity, and any production agency licensed by the department involved in the transaction, all financial and operational information relative to the content and scope of the plan and, specifically, as to the lack of insurance or other coverage.

Any production agency obtaining knowledge of any coverage relative to the content and scope of a hospital service plan or health care service plan, as required under this subdivision, shall advise and disclose to any purchaser, prospective purchaser, covered person or entity, the knowledge regarding the content and scope of the plan and, specifically, as to the lack of insurance by an admitted carrier or other qualified plan.

(g) A health care service plan, as defined in Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, shall not be subject to this section.

(h) The department shall notify, in writing, the Director of the Department of Managed Health Care whenever it determines that a multiple employer trust qualifies as a health care service plan subject to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(i) Any health care service plan, including a self-insured reimbursement plan that pays for or reimburses any part of the cost of health care services, operated by any city, county, city and county, public entity, or political subdivision, or a public joint labor management trust as described in subdivision (c) of Section 1349.2 of the Health and Safety Code, that is exempt pursuant to Section 1349.2 of the Health and Safety Code from the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), is also exempt from this code.

SEC. 54. Section 742.407 of the Insurance Code is amended to read:

742.407. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee’s medical records by a multiple employer welfare arrangement.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as

determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's ''written authorization,'' as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of

Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Health Care necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

SEC. 55. Section 742.435 of the Insurance Code is amended to read:

742.435. The Department of Insurance, in consultation with the Department of Managed Health Care, shall conduct an evaluation of multiple employer welfare arrangements and report to the Legislature and the Governor by January 1, 2002. The evaluation shall include, but not be limited to, the effectiveness of multiple employer welfare arrangements in providing participants with options for affordable health care coverage, and the effect of multiple employer welfare arrangements on persons or entities purchasing health care coverage who are not multiple employer welfare arrangement participants.

SEC. 56. Section 791.02 of the Insurance Code is amended to read:

791.02. As used in this act:

(a) (1) ''Adverse underwriting decision'' means any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

(A) A declination of insurance coverage.

(B) A termination of insurance coverage.

(C) Failure of an agent to apply for insurance coverage with a specific insurance institution that the agent represents and that is requested by an applicant.

(D) In the case of a property or casualty insurance coverage:

(i) Placement by an insurance institution or agent of a risk with a residual market mechanism, with an unauthorized insurer, or with an insurance institution that provides insurance to other than preferred or standard risks, if in fact the placement is at other than a preferred or standard rate. An adverse underwriting decision, in case of placement with an insurance institution which provides insurance to other than preferred or standard risks, shall not include such placement where the applicant or insured did not specify or apply for placement as a preferred or standard risk or placement with a particular company insuring preferred or standard risks, or

(ii) The charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished.

(E) In the case of a life, health, or disability insurance coverage, an offer to insure at higher than standard rates.

(2) Notwithstanding paragraph (1), any of the following actions shall not be considered adverse underwriting decisions but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

(A) The termination of an individual policy form on a class or statewide basis.

(B) A declination of insurance coverage solely because such coverage is not available on a class or statewide basis.

(C) The rescission of a policy.

(b) ''Affiliate'' or ''affiliated'' means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

(c) ''Agent'' means any person licensed pursuant to Chapter 5 (commencing with Section 1621), Chapter 5A (commencing with Section 1759), Chapter 6 (commencing with Section 1760), Chapter 7 (commencing with Section 1800), or Chapter 8 (commencing with Section 1831).

(d) ''Applicant'' means any person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

(e) ''Consumer report'' means any written, oral, or other communication of information bearing on a natural person's creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that is used or expected to be used in connection with an insurance transaction.

(f) ''Consumer reporting agency'' means any person who:

(1) Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee.

(2) Obtains information primarily from sources other than insurance institutions.

(3) Furnishes consumer reports to other persons.

(g) ''Control,'' including the terms ''controlled by'' or ''under common control with,'' means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(h) ''Declination of insurance coverage'' means a denial, in whole or in part, by an insurance institution or agent of requested insurance coverage.

(i) ''Individual'' means any natural person who:

(1) In the case of property or casualty insurance, is a past, present or proposed named insured or certificate holder;

(2) In the case of life or disability insurance, is a past, present or proposed principal insured or certificate holder;

(3) Is a past, present or proposed policyowner;

(4) Is a past or present applicant;

(5) Is a past or present claimant; or

(6) Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this act.

(j) ‘‘Institutional source’’ means any person or governmental entity that provides information about an individual to an agent, insurance institution, or insurance-support organization, other than:

(1) An agent,

(2) The individual who is the subject of the information, or

(3) A natural person acting in a personal capacity rather than in a business or professional capacity.

(k) ‘‘Insurance institution’’ means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd’s insurer, fraternal benefit society, or other person engaged in the business of insurance. ‘‘Insurance institution’’ shall not include agents, insurance-support organizations, or health care service plans regulated pursuant to the Knox-Keene Health Care Service Plan Act, Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(*l*) ‘‘Insurance-support organization’’ means:

(1) Any person who regularly engages, in whole or in part, in the business of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or agent for insurance transactions, including:

(A) The furnishing of consumer reports or investigative consumer reports to an insurance institution or agent for use in connection with an insurance transaction, or

(B) The collection of personal information from insurance institutions, agents, or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(2) Notwithstanding paragraph (1), the following persons shall not be considered ‘‘insurance-support organizations’’: agents, governmental institutions, insurance institutions, medical care institutions, medical professionals, and peer review committees.

(m) ‘‘Insurance transaction’’ means any transaction involving insurance primarily for personal, family, or household needs rather than business or professional needs that entails:

(1) The determination of an individual’s eligibility for an insurance coverage, benefit, or payment, or

(2) The servicing of an insurance application, policy, contract, or certificate.

(n) ‘‘Investigative consumer report’’ means a consumer report or portion thereof in which information about a natural person’s character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person’s neighbors, friends, associates, acquaintances, or others who may have knowledge concerning those items of information.

(o) ‘‘Medical care institution’’ means any facility or institution that is licensed to provide health care services to natural persons,

including but not limited to, hospitals, skilled nursing facilities, home health agencies, medical clinics, rehabilitation agencies, and public health agencies.

(p) ''Medical professional'' means any person licensed or certified to provide health care services to natural persons, including but not limited to, a physician, dentist, nurse, optometrist, physical or occupational therapist, psychiatric social worker, clinical dietitian, clinical psychologist, chiropractor, pharmacist, or speech therapist.

(q) ''Medical record information'' means personal information that:

(1) Relates to an individual's physical or mental condition, medical history or medical treatment, and

(2) Is obtained from a medical professional or medical care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

(r) ''Person'' means any natural person, corporation, association, partnership, limited liability company, or other legal entity.

(s) ''Personal information'' means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. ''Personal information'' includes an individual's name and address and ''medical record information'' but does not include ''privileged information.''

(t) ''Policyholder'' means any person who:

(1) In the case of individual property or casualty insurance, is a present named insured;

(2) In the case of individual life or disability insurance, is a present policyowner; or

(3) In the case of group insurance, which is individually underwritten, is a present group certificate holder.

(u) ''Pretext interview'' means an interview whereby a person, in an attempt to obtain information about a natural person, performs one or more of the following acts:

(1) Pretends to be someone he or she is not,

(2) Pretends to represent a person he or she is not in fact representing,

(3) Misrepresents the true purpose of the interview, or

(4) Refuses to identify himself or herself upon request.

(v) ''Privileged information'' means any individually identifiable information that both:

(1) Relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual.

(2) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual. However, information otherwise meeting the requirements of this division shall nevertheless be considered

‘‘personal information’’ under this act if it is disclosed in violation of Section 791.13.

(w) ‘‘Residual market mechanism’’ means the California FAIR Plan Association, Chapter 10 (commencing with Section 10101) of Part 1 of Division 2, and the assigned risk plan, Chapter 1 (commencing with Section 11550) of Part 3 of Division 2.

(x) ‘‘Termination of insurance coverage’’ or ‘‘termination of an insurance policy’’ means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

(y) ‘‘Unauthorized insurer’’ means an insurance institution that has not been granted a certificate of authority by the director to transact the business of insurance in this state.

(z) ‘‘Commissioner’’ means the Insurance Commissioner; except in the case of a person or entity subject to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), and except as to any person defined in subdivision (k) when engaged in providing information or evaluation to a person or entity subject to the provisions of that act, and in those instances only, the term ‘commissioner‘ shall mean the Director of the Department of Managed Health Care.

(aa) ‘Insurance‘ includes a medical service or hospital service agreement or contract issued by a person or entity subject to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

SEC. 57. Section 1068 of the Insurance Code is amended to read:

1068. (a) As used in this section, the following definitions shall apply:

(1) ‘‘Health care service plan’’ means any plan as defined in Section 1345 of the Health and Safety Code, but this section does not apply to specialized health care service contracts.

(2) ‘‘Carrier’’ means a health care service plan, an insurer issuing group disability coverage which covers hospital, medical, or surgical expenses, a nonprofit hospital service plan, or any other entity responsible for either the payment of benefits for or the provision of hospital, medical, and surgical benefits under a group contract.

(3) ‘‘Insolvency’’ means that the Director of the Department of Managed Health Care has determined that the health care service plan is not financially able to provide health care services to its enrollees and (A) the Director of the Department of Managed Health Care has taken an action pursuant to Section 1386, 1391, or 1399 of the Health and Safety Code, or (B) an order requested by the Director of the Department of Managed Health Care or the Attorney General has been issued by the superior court under Section 1392, 1393, or 1394.1 of the Health and Safety Code.

(b) In the event of the insolvency of a health care service plan, upon order of the commissioner which shall be issued following his or her receipt of a notice issued by the Director of the Department of Managed Health Care pursuant to Section 1394.7 of the Health and Safety Code, any insurer, nonprofit hospital service plan, and any other entity, other than a health care service plan, responsible for either the payment of benefits for or the provision of hospital, medical, and surgical benefits under a group contract, that participated in the enrollment process with the insolvent health care service plan at the last regular open enrollment period of a group, shall offer enrollees of the group in the insolvent health care service plan a 30-day enrollment period commencing upon the date of insolvency. Each such carrier shall offer enrollees of the group in the insolvent health care service plan the same coverages and rates that it offered to enrollees of the group at the last regular open enrollment period of the group.

SEC. 58. Section 1068.1 of the Insurance Code is amended to read:

1068.1. (a) As used in this section:

(1) ''Carrier'' means a specialized health care service plan, and any of the following entities which offer coverage comparable to the coverages offered by a specialized health care service plan: an insurer issuing group disability coverage; a nonprofit hospital service plan; or other entity responsible for either the payment of benefits for or the provision of services under a group contract.

(2) ''Insolvency'' means that the Director of the Department of Managed Health Care has determined that the specialized health care service plan is not financially able to provide specialized health care services to its enrollees and (A) the Director of the Department of Managed Health Care has taken an action pursuant to Section 1386, 1391, or 1399 of the Health and Safety Code, or (B) an order requested by the commissioner or the Attorney General has been issued by the superior court under Section 1392, 1393, or 1394.1 of the Health and Safety Code.

(3) ''Specialized health care service plan'' means any plan authorized to issue only specialized health care service plan contracts as defined in Section 1345 of the Health and Safety Code.

(b) In the event of the insolvency of a specialized health care service plan, upon order of the commissioner which shall be issued following his or her receipt of a notice issued by the Director of the Department of Managed Health Care pursuant to Section 1394.8 of the Health and Safety Code, all carriers that participated in the enrollment process with the insolvent specialized health care service plan at a group's last regular open enrollment period for the same type of specialized health care service benefits shall offer the group's enrollees in the insolvent specialized health care service plan a 30-day enrollment period commencing upon the date of insolvency. Each such carrier shall offer enrollees of the insolvent specialized

health care service plan the same specialized coverage and rates that it had offered to the enrollees of the group at its last regular open enrollment period.

SEC. 59. Section 10123.35 of the Insurance Code is amended to read:

10123.35. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by a self-insured welfare benefit plan.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's ''written authorization,'' as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Health Care necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

SEC. 60. Section 10140.1 of the Insurance Code is amended to read:

10140.1. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by an admitted insurer licensed to issue life or disability insurance, except life and disability income policies issued or delivered on or after January 1, 1995, that are contingent upon review or testing for other diseases or medical conditions.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics, of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written

authorization as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's ''written authorization,'' as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Health Care necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

SEC. 60.5. Section 10123.68 of the Insurance Code is amended to read:

10123.68. (a) When requested by an insured or contracting health professional who is treating an insured, a disability insurer that covers hospital, medical, or surgical expenses shall authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If the insured questions the reasonableness or necessity of recommended surgical procedures.

(2) If the insured questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the insured requests an additional diagnosis.

(4) If the treatment plan in progress is not improving the medical condition of the insured within an appropriate period of time given the diagnosis and plan of care, and the insured requests a second opinion regarding the diagnosis or continuance of the treatment.

(5) If the insured has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

(b) For purposes of this section, an appropriately qualified health care professional is a primary care physician, specialist, or other licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

(c) If an insured or participating health professional who is treating an insured requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. When the insured's condition is such that the insured faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain maximum function, the second opinion shall be authorized or denied in a timely fashion appropriate to the nature of the insured's condition, no to exceed 72 hours after the insurer's receipt of the request, whenever possible. Each insurer shall file with the Department of Insurance timelines for responding to requests for second opinions for cases involving emergency needs, urgent care, and other requests by July 1, 2000, and within 30 days of any amendment to the timelines. The timelines shall be made available to the public upon request.

(d) If an insurer approves a request by an insured for a second opinion, the insured shall be responsible only for the costs of applicable copayments that the insurer requires for similar referrals.

(e) If the insured is requesting a second opinion about care from his or her primary care physician, the second opinion shall be provided by an appropriately qualified health care professional of the insured's choice who is contracted with the insurer.

(f) If the insured is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of

the same or equivalent specialty, of the insured's choice, within the insurer's provider network, if the insurance contract limits second opinions to within a network.

(g) The insurer may limit second opinions to its network of providers if the insurance contract limits the benefit to within a network of providers and there is a participating provider who meets the standard specified in subdivision (b). If there is no participating provider who meets this standard, then the insurer shall authorize a second opinion by an appropriately qualified health professional outside of the insurer's provider network. In approving a second opinion either inside or outside of the insurer's provider network, the insurer shall take into account the ability of the insured to travel to the provider.

(h) The insurer shall require the second opinion health professional to provide the insured and the initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate. Nothing in this section shall be construed to prevent the insurer from authorizing, based on its independent determination, additional medical opinions concerning the medical condition of an insured.

(i) If the insurer denies a request by an insured for a second opinion, it shall notify the insured in writing of the reasons for the denial and shall inform the insured of the right to dispute the denial, and the procedures for exercising that right.

(j) If the insurance contract limits health care services to within a network of providers, in order for coverage to be in force, the insured shall obtain services only from a provider who is participating in, or under contract with, the insurer pursuant to the specific insurance contract under which the insured is entitled to health care service benefits.

(k) This section shall not apply to any policy or contract of disability insurance that covers hospital, medical, or surgical expenses and that does not limit second opinions, subject to all other terms and conditions of the contract.

(*l*) This section shall not apply to accident-only, specified disease, or hospital indemnity health insurance policies.

SEC. 61. Section 10169 of the Insurance Code is amended to read:

10169. (a) Commencing January 1, 2001, there is hereby established in the department the Independent Medical Review System.

(b) For the purposes of this chapter, ''disputed health care service'' means any health care service eligible for coverage and payment under a disability insurance contract that has been denied, modified, or delayed by a decision of the insurer, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed

health care service relates to the practice of medicine and is not a coverage decision. A disputed health care service does not include services provided by a group or individual policy of vision-only or dental-only coverage, except to the extent that (1) the service involves the practice of medicine, or (2) is provided pursuant to a contract with a disability insurer that covers hospital, medical, or surgical benefits. If an insurer, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the insured, the statement of decision shall clearly specify the provision in the contract that excludes that coverage.

(c) For the purposes of this chapter, ''coverage decision'' means the approval or denial of health care services by a disability insurer, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the disability insurance contract. A coverage decision does not encompass a disability insurer or contracting provider decision regarding a disputed health care service.

(d) (1) All insured grievances involving a disputed health care service are eligible for review under the Independent Medical Review System if the requirements of this article are met. If the department finds that an insured grievance involving a disputed health care service does not meet the requirements of this article for review under the Independent Medical Review System, the insured request for review shall be treated as a request for the department to review the grievance. All other insured grievances, including grievances involving coverage decisions, remain eligible for review by the department.

(2) In any case in which an insured or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this article.

(3) The department shall be the final arbiter when there is a question as to whether an insured grievance is a disputed health care service or a coverage decision. The department shall establish a process to complete an initial screening of an insured grievance. If there appears to be any medical necessity issue, the grievance shall be resolved pursuant to an independent medical review as provided under this article.

(e) Every disability insurance contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall, effective, January 1, 2001, provide an insured with the opportunity to seek an independent medical review whenever health care services

have been denied, modified, or delayed by the insurer, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. For purposes of this article, an insured may designate an agent to act on his or her behalf. The provider may join with or otherwise assist the insured in seeking an independent medical review, and may advocate on behalf of the insured.

(f) Medicare beneficiaries enrolled in Medicare + Choice products shall not be excluded unless expressly preempted by federal law.

(g) The department may seek to integrate the quality of care and consumer protection provisions, including remedies, of the Independent Medical Review System with related dispute resolution procedures of other health care agency programs, including the Medicare program, in a way that minimizes the potential for duplication, conflict, and added costs. Nothing in this subdivision shall be construed to limit any rights conferred upon insureds under this chapter.

(h) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available.

(i) No later than January 1, 2001, every disability insurer shall prominently display in every insurer member handbook or relevant informational brochure, in every insurance contract, on insured evidence of coverage forms, on copies of insurer procedures for resolving grievances, on letters of denials issued by either the insurer or its contracting organization, and on all written responses to grievances, information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.

(j) An insured may apply to the department for an independent medical review when all of the following conditions are met:

(1) (A) The insured’s provider has recommended a health care service as medically necessary, or

(B) The insured has received urgent care or emergency services that a provider determined was medically necessary, or

(C) The insured, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by a contracting provider for the diagnosis or treatment of the medical condition for which the insured seeks independent review. The insurer shall expedite access to a contracting provider upon request of an insured. The contracting provider need not recommend the disputed health care service as a condition for the insured to be eligible for an independent review.

For purposes of this article, the insured's provider may be a noncontracting provider. However, the insurer shall have no liability for payment of services provided by a noncontracting provider, except as provided pursuant to Section 10169.3.

(2) The disputed health care service has been denied, modified, or delayed by the insurer, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.

(3) The insured has filed a grievance with the insurer or its contracting provider, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The insured shall not be required to participate in the insurer's grievance process for more than 30 days. In the case of a grievance that requires expedited review, the insured shall not be required to participate in the insurer's grievance process for more than three days.

(k) An insured may apply to the department for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary, within six months of any of the qualifying periods or events under subdivision (j). The commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

(*l*) The insured shall pay no application or processing fees of any kind.

(m) As part of its notification to the insured regarding a disposition of the insured's grievance that denies, modifies, or delays health care services, the insurer shall provide the insured with a one-page application form approved by the department, and an addressed envelope, which the insured may return to initiate an independent medical review. The insurer shall include on the form any information required by the department to facilitate the completion of the independent medical review, such as the insured's diagnosis or condition, the nature of the disputed health care service sought by the insured, a means to identify the insured's case, and any other material information. The form shall also include the following:

(1) Notice that a decision not to participate in the independent review process may cause the insured to forfeit any statutory right to pursue legal action against the insurer regarding the disputed health care service.

(2) A statement indicating the insured's consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any noncontracting provider the insured may have consulted on the matter, to be signed by the insured.

(3) Notice of the insured's right to provide information or documentation, either directly or through the insured's provider, regarding any of the following:

(A) A provider recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.

(B) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.

(C) Reasonable information supporting the insured's position that the disputed health care service is or was medically necessary for the insured's medical condition, including all information provided to the insured by the insurer or any of its contracting providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.

(n) Upon notice from the department that the insured has applied for an independent medical review, the insurer or its contracting providers, shall provide to the independent medical review organization designated by the department a copy of all of the following documents within three business days of the insurer's receipt of the department's notice of a request by an insured for an independent review:

(1) (A) A copy of all of the insured's medical records in the possession of the insurer or its contracting providers relevant to each of the following:

(i) The insured's medical condition.

(ii) The health care services being provided by the insurer and its contracting providers for the condition.

(iii) The disputed health care services requested by the insured for the condition.

(B) Any newly developed or discovered relevant medical records in the possession of the insurer or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The insurer shall concurrently provide a copy of medical records required by this subparagraph to the insured or the insured's provider, if authorized by the insured, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(2) A copy of all information provided to the insured by the insurer and any of its contracting providers concerning insurer and provider decisions regarding the insured's condition and care, and a copy of any materials the insured or the insured's provider submitted to the insurer and to the insurer's contracting providers in support of the insured's request for disputed health care services. This documentation shall include the written response to the insured's

grievance. The confidentiality of any insured medical information shall be maintained pursuant to applicable state and federal laws.

(3) A copy of any other relevant documents or information used by the insurer or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the insurer and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The insurer shall concurrently provide a copy of documents required by this paragraph, except for any information found by the commissioner to be legally privileged information, to the insured and the insured's provider. The department and the independent review organization shall maintain the confidentiality of any information found by the commissioner to be the proprietary information of the insurer.

SEC. 62. Section 10169.2 of the Insurance Code is amended to read:

10169.2. (a) By January 1, 2001, the department shall contract with one or more independent medical review organizations in the state to conduct reviews for purposes of this article. The independent medical review organizations shall be independent of any disability insurer doing business in this state. The commissioner may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, that an organization shall be required to meet in order to qualify for participation in the Independent Medical Review System and to assist the department in carrying out its responsibilities.

(b) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be medical consultants for purposes of Section 43.98 of the Civil Code.

(c) The independent medical review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent medical review organization shall not have any material professional, familial, or financial affiliation, as determined by the commissioner, with any of the following:

(1) The insurer.

(2) Any officer, director, or employee of the insurer.

(3) A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the insurer, would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the insured whose treatment is under review, or the alternative therapy, if any, recommended by the insurer.

(6) The insured or the insured's immediate family.

(d) In order to contract with the department for purposes of this article, an independent medical review organization shall meet all of the following requirements:

(1) The organization shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a disability insurer or a trade association of insurers. A board member, director, officer, or employee of the independent medical review organization shall not serve as a board member, director, or employee of a disability insurer. A board member, director, or officer of a disability insurer or a trade association of insurers shall not serve as a board member, director, officer, or employee of an independent medical review organization.

(2) The organization shall submit to the department the following information upon initial application to contract for purposes of this article and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars ($100,000), if any.

(C) The names of all corporations and organizations that the independent medical review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the independent medical review organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care organization, provider group, or board or committee of an insurer, a plan, a managed care organization, or a provider group.

(E) (i) The percentage of revenue the independent medical review organization receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, and utilization reviews.

(ii) The names of any insurer or provider group for which the independent medical review organization provides review services, including, but not limited to, utilization review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.

(F) A description of the review process including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(G) A description of the system the independent medical review organization uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the

number of medical professionals credentialed, and the types of cases and areas of expertise that the medical professionals are credentialed to review.

(H) A description of how the independent medical review organization ensures compliance with the conflict-of-interest provisions of this section.

(3) The organization shall demonstrate that it has a quality assurance mechanism in place that does the following:

(A) Ensures that the medical professionals retained are appropriately credentialed and privileged.

(B) Ensures that the reviews provided by the medical professionals are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the medical professionals retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts-of-interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent medical review organizations to review medical treatment decisions shall be physicians or other appropriate providers who meet the following minimum requirements:

(A) The medical professional shall be a clinician knowledgeable in the treatment of the insured's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) Notwithstanding any other provision of law, the medical professional shall hold a nonrestricted license in the any state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. The independent medical review organization shall give preference to the use of a physician licensed in California as the reviewer, except when training and experience with the issue under review reasonably requires the use of an out-of-state reviewer.

(C) The medical professional shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(5) Neither the expert reviewer, nor the independent medical review organization, shall have any material professional, material familial, or material financial affiliation with any of the following:

(A) The disability insurer or a provider group of the insurer, except that an academic medical center under contract to the insurer to provide services to insureds may qualify as an independent medical review organization provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the insurer.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the insured whose condition is under review.

(F) The insured or the insured's immediate family.

(6) For purposes of this section, the following terms shall have the following meanings:

(A) ''Material familial affiliation'' means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(B) ''Material professional affiliation'' means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent medical review organization. ''Material professional affiliation'' does not include affiliations that are limited to staff privileges at a health facility.

(C) ''Material financial affiliation'' means any financial interest of more than 5 percent of total annual revenue or total annual income of an independent medical review organization or individual to which this subdivision applies. ''Material financial affiliation'' does not include payment by the insurer to the independent medical review organization for the services required by this section, nor does ''material financial affiliation'' include an expert's participation as a contracting provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(e) The department shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the commissioner, filed with it by an independent medical review organization seeking to contract under this article. The department may charge a nominal fee to the interested person for photocopying the requested information.

(f) The commissioner may contract with the Department of Managed Health Care to administer the independent medical review process established by this article.

SEC. 63. Section 10169.3 of the Insurance Code is amended to read:

10169.3. (a) Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the insured, provider reports, as well as any other information submitted to the organization as authorized by the department or requested from any of the parties to the dispute by the reviewers. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (b).

(b) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the insured and any of the following:

(A) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(B) Nationally recognized professional standards.

(C) Expert opinion.

(D) Generally accepted standards of medical practice.

(E) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(c) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the commissioner. If the disputed health care service has not been provided and the insured's provider or the department certifies in writing that an imminent and serious threat to the health of the insured may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the insured, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the department, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the commissioner for up to three days in extraordinary circumstances or for good cause.

(d) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the insured's medical condition, the relevant documents in the record, and the relevant findings associated with

the provisions of subdivision (b) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(e) The independent medical review organization shall provide the director, the insurer, the insured, and the insured's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization, except in cases where the reviewer is called to testify and in response to court orders. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(f) The commissioner shall immediately adopt the determination of the independent medical review organization, and shall promptly issue a written decision to the parties that shall be binding on the insurer.

(g) After removing the names of the parties, including, but not limited to, the insured, all medical providers, the insurer, and any of the insurer's employees or contractors, commissioner decisions adopting a determination of an independent medical review organization shall be made available by the department to the public upon request, at the department's cost and after considering applicable laws governing disclosure of public records, confidentiality, and personal privacy.

SEC. 64. Section 10169.5 of the Insurance Code is amended to read:

10169.5. (a) After considering the results of a competitive bidding process and any other relevant information on program costs, the commissioner shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.

(b) The costs of the independent medical review system for insureds shall be borne by disability insurers pursuant to an assessment fee system established by the commissioner. In determining the amount to be assessed, the commissioner shall consider all appropriations available for the support of this article, and existing fees paid to the department. The commissioner may adjust fees upward or downward, on a schedule set by the department, to address shortages or overpayments, and to reflect utilization of the independent review process.

(c) The commissioner may contract with the Department of Managed Health Care to administer the requirements of this article.

SEC. 65. Section 10196 of the Insurance Code is amended to read:

10196. (a) The commissioner, with the advice of the Department of Managed Health Care, shall prepare a guide that explains the factors to be considered in selecting long-term care insurance and the consequences of particular clauses and exclusions. The guide shall be made available to the public and to interested organizations upon request. Any advertisement in this state dealing with long-term care insurance shall include notice of availability of this guide from the commissioner.

(b) For purposes of this section, ''long-term care insurance'' means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. ''Long-term care insurance'' does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, or specified disease or accident coverage.

SEC. 66. Section 10270.98 of the Insurance Code is amended to read:

10270.98. Group disability policies may provide, among other things, that the benefits payable thereunder are subject to reduction if the individual insured has any other coverage (other than individual policies or contracts) providing hospital, surgical or medical benefits, whether on an indemnity basis or a provision of service basis, resulting in such insured being eligible for more than 100 percent of the covered expenses.

Except as permitted by this section and by Section 10323, 10369.5, 10369.6, or 11515.5, and except in the case of group practice prepayment plan contracts which do not provide for coordination of benefits, to the extent they provide for a reduction of benefits on account of other coverage with respect to emergency services that are not obtained from providers that contract with the plan, no group or individual disability insurance policy or service contract issued by nonprofit hospital service plans operating under Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 shall limit payment of benefits by reason of the existence of other insurance or service coverage.

The policy provisions authorized by this section shall contain a provision that payments of funds may be made directly between

insurers and other providers of benefits. Such policy provisions shall also contain a provision that if benefits are provided in the form of services rather than cash payments the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. The reasonable cash value of any contractual benefit provided to the insured in the form of service rather than cash payment by or through any hospital service organization or medical service organization or group-practice prepayment plan shall be deemed an expense incurred by the insured for such service, whether or not actually incurred, and the liability of the insurer shall be the same as if the insured had not been entitled to any such service benefit, unless the policy contains a provision authorized by Section 10323, 10369.5 or 10369.6 in the case of an individual disability policy, or by this section, in the case of a group disability policy.

This section shall not be construed to require that benefits payable under group disability policies be subject to reduction by the benefit amounts payable under Chapter 3 (commencing with Section 2800) of Part 2 of Division 1 of the Unemployment Insurance Code.

The provisions of this section, and all regulations adopted pursuant thereto pertaining to coordination of benefits with other group disability benefits, shall apply to all employers, labor-management trustee plans, union welfare plans (including those established in conformity with 29 U.S.C. Sec. 186), employer organization plans or employee benefit organization plans, health care service plan contracts, pursuant to regulations adopted by the Director of the Department of Managed Health Care which shall be uniform with those issued under this section for those plans that elect to coordinate benefits, group practice, individual practice, any other prepayment coverage for medical or dental care or treatment, and administrators, within the meaning of Section 1759 not otherwise subject to the provisions of this section whenever such plan, contract or practice provides or administers hospital, surgical, medical or dental benefits to employees or agents who are also covered under one or more additional group disability policies which are subject to this section or health care service plans.

SEC. 67. Section 10704 of the Insurance Code is amended to read:

10704. The commissioner may issue regulations that are necessary to carry out the purposes of this chapter. Prior to the public comment period required on the regulations under the Administrative Procedure Act, the commissioner shall provide the Director of the Department of Managed Health Care with a copy of the proposed regulations. The Director of the Department of Managed Health Care shall have 30 days to notify the commissioner in writing of any comments on the regulations. The Director of the Department of Managed Health Care's comments shall be included in the public notice issued on the regulations. Any rules and regulations issued pursuant to this subdivision may be adopted as

emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Until December 31, 1994, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The regulations shall be enforced by the director.

SEC. 68. Section 10733 of the Insurance Code is amended to read:

10733. On or after the effective date of this chapter, the board shall enter into contracts with carriers for the purpose of providing health benefits coverage to eligible employees and dependents. Participating carriers shall have, but need not be limited to, all of the following operating characteristics satisfactory to the board:

(a) Strong financial condition, including the ability to assume the risk of providing and paying for covered services. A participating carrier may utilize reinsurance, provider risk sharing, and other appropriate mechanisms to share a portion of the risk.

(b) Adequate administrative management.

(c) In the case of the health care service plan, the following requirements must be met: (1) on the effective date of the contract, the health care service plan must be in compliance with the minimum tangible net equity requirements of the Director of the Department of Managed Health Care as those requirements will be in effect on January 1, 1995, and must remain in compliance with these requirements throughout the duration of the contract; (2) (A) before the effective date of the contract, the health care service plan must have devised a system for identifying in a simple and clear fashion both in its own records and in the medical records of subscribers and enrollees the fact that the services provided are provided under the program; and (B) throughout the duration of the contract, the health care service plan must use that system; and (3) at least 30 days before the effective date of any contract with the board, the health care service plan must inform the Director of the Department of Managed Health Care in writing of the health care service plan's intent to enter into the contract and must demonstrate in that letter, to the satisfaction of the Director of the Department of Managed Health Care, that it has complied with the requirements of paragraphs (1) and (2).

(d) A satisfactory grievance procedure.

(e) Participating carriers that contract with or employ health care providers shall have mechanisms to accomplish all of the following, in a manner satisfactory to the board, in consultation with the carrier's licensing agency.

(1) Review the quality of care covered.

(2) Review the appropriateness of care covered.

(3) Provide accessible health care services.

SEC. 69. Section 10734 of the Insurance Code is amended to read:

10734. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care, as the case may be.

(b) Participating carriers that contract with the program shall be licensed and in good standing with their licensing agencies.

SEC. 70. Section 10810 of the Insurance Code is amended to read:

10810. As used in this chapter:

(a) ''Ancillary benefit plan'' means a policy or contract written or administered by a participating carrier that covers dental or vision benefits for the covered eligible employees of an employer or small employer and their dependents.

(b) ''Appropriate Regulatory Authority'' means the Department of Insurance except for health care service plans, in which case it means the Department of Managed Health Care.

(c) ''Benefit plan design'' means a specific health coverage product issued by a carrier to employers or small employers, to trustees of associations, or to individuals if the coverage is offered through employment or sponsored by an employer or small employer. It includes the services covered and the levels of copayment and deductibles.

(d) ''Board'' means the governing body of the purchasing alliance. This term shall include the board of directors of a nonprofit corporation or trust, a for-profit corporation, the general partners of a partnership, or a sole proprietor.

(e) ''Carrier'' means any licensed disability insurance company or licensed health care service plan or any other entity that writes, issues, or administers any health benefit plan or ancillary benefit plan to employers or small employers in this state.

(f) ''Commissioner'' means the Insurance Commissioner, who shall have regulatory jurisdiction over purchasing alliances.

(g) ''Dependent'' has the same meaning as in the subdivision (a) of Section 1357 of the Health and Safety Code and in subdivision (e) of Section 10700 of this code.

(h) ''Eligible employee'' means any permanent employee who is actively engaged on a full-time basis in the conduct of business of the employer or small employer and, who has satisfied any employer or small employer waiting period requirements. The term includes sole proprietors or partners of a partnership if they are actively engaged on a full-time basis in the employer's or small employer's business, but does not include employees who work on a part-time, temporary, or substitute basis.

(i) ''Employer'' means any corporation, partnership, sole proprietorship, or other business entity doing business in this state that may be eligible to participate in a purchasing alliance. The term ''employer'' shall not include ''small employer'' as defined in subdivision (s).

(j) ‘‘Enrollee’’ means an eligible employee or a dependent of an eligible employee who is enrolled in a health benefit plan or ancillary benefit plan offered through the purchasing alliance by a participating carrier.

(k) ‘‘Health benefit plan’’ means a policy or contract written or administered by a participating carrier that arranges or provides health care benefits for the covered eligible employees of an employer or small employer and their dependents. The term does not include accident only, credit, dental, vision, disability income, or long-term care insurance, coverage issued as a supplement to liability insurance, automobile medical payments insurance, or insurance under which benefits are payable with or without regard to fault and is statutorily required to be continued in any liability insurance policy or equivalent self-insurance.

(*l*) ‘‘Management company’’ means the company under contract to the purchasing alliance to provide managerial services for the operation of the purchasing alliance.

(m) ‘‘Participating carrier’’ means a carrier that contracts with a purchasing alliance to provide coverage to enrollees under a health benefit plan or ancillary benefit plan.

(n) ‘‘Participating employer’’ means an employer or small employer who contracts with a purchasing alliance to provide coverage to the employer’s or small employer’s employees.

(o) ‘‘Purchasing alliance’’ means a non-risk-bearing entity issued a certificate of registration pursuant to this chapter to provide health benefits through multiple unaffiliated participating carriers to multiple participating employers, small employers and their employees within this state as authorized by the commissioner. That entity shall include nonprofit corporations, for-profit corporations, trusts, partnerships, and sole proprietorships.

(p) ‘‘Risk adjustment factor’’ for small employer benefit plan designs and contracts has the same meaning as in subdivision (j) of Section 1357 of the Health and Safety Code and in subdivision (u) of Section 10700 of this code.

(q) ‘‘Service region’’ means that portion of the state, designated by the commissioner pursuant to regulations as described in this chapter in which each purchasing alliance must fairly and affirmatively offer, market, and sell all of the health benefit plan designs offered through the purchasing alliance that are sold or offered to a small employer to all small employers.

(r) ‘‘Small employer’’ has the same meaning as in paragraph (1) of subdivision (*l*) of Section 1357 of the Health and Safety Code and in paragraph (1) of subdivision (w) of Section 10700 of this code.

(s) ‘‘Third-party administrator’’ means the company contracted by the purchasing alliance to provide administrative services for the purchasing alliance and that is licensed to provide those services by the department pursuant to Section 1759.10.

SEC. 71. Section 10820 of the Insurance Code is amended to read:

10820. (a) The commissioner shall regulate the establishment and conduct of purchasing alliances as set forth in this chapter.

(b) No person or entity may market, sell, offer, or contract for a package of one or more health benefit plans underwritten by two or more carriers to two or more employers or small employers or their eligible employees within a purchasing alliance without first being registered by the commissioner pursuant to this chapter. This subdivision does not apply to entities licensed by the Department of Managed Health Care as health care service plans or entities licensed by the Department of Insurance as disability insurers except that no licensed health care service plan or licensed disability insurer may be registered with the commissioner as a purchasing alliance. This chapter does not apply to any entity exempt pursuant to Section 1349.2 of the Health and Safety Code.

(c) A person or entity not registered by the commissioner as a purchasing alliance and engaged in the purchase, sale, marketing or distribution of health insurance or health care benefit plans shall not hold itself out as an alliance, health insurance purchasing alliance, purchasing alliance, health alliance, health insurance purchasing cooperative, or purchasing cooperative, or otherwise use a confusingly similar name.

(d) The commissioner shall establish six geographic service regions throughout which all purchasing alliances shall operate. These regions shall be established with no region smaller than an area in which the first three digits of all its postal ZIP Codes are in common within a county and shall divide no county into more than two service regions. Geographic service regions established pursuant to this section shall, as a group, cover the entire state, and the areas encompassed in geographic service regions shall be separate and distinct from regions encompassed in other geographic service regions. Geographic service regions may be noncontiguous.

(e) Nothing in this chapter shall be deemed to be in conflict with or limit the duties and powers granted to the commissioner under the laws of this state.

(f) Purchasing alliances shall report to the commissioner any suspected or alleged law violations of this chapter.

(g) Violations of this chapter shall be subject to the penalties outlined hereafter.

(h) The commissioner shall adopt reasonable rules and regulations as are necessary to administer this chapter.

(i) Nothing in this chapter shall be construed or interpreted to apply to an entity that has been approved by the Director of the Department of Managed Health Care, pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to act as a solicitor and third-party administrator with respect to a multiple carrier or health care service plan marketing

cooperative in which each carrier or health care service plan contracts directly with subscribing groups or individuals for the provision of health care, for the arranging for the provision of health care, or for the provision of coverage for health care.

SEC. 72. Section 10856 of the Insurance Code is amended to read:

10856. Nothing in this article shall be construed to limit the existing regulatory authority of the Department of Managed Health Care to regulate health care service plans or of the Department of Insurance to regulate disability or life insurers or hospital service plans. None of the requirements of this article shall conflict with the participating carrier's licensing requirements.

SEC. 73. Section 12693.36 of the Insurance Code is amended to read:

12693.36. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care, as the case may be.

(b) Participating health, dental, and vision plans that contract with the program and are regulated by either the Insurance Commissioner or the Department of Managed Health Care shall be licensed and in good standing with their respective licensing agencies. In their application to the program, those entities shall provide assurance of their standing with the appropriate licensing entity.

(c) Local initiatives that have a contract with the State Department of Health Services, and that contract with the program, and that are licensed by the Department of Managed Health Care but do not have a commercial license from the Department of Managed Health Care, may contract with the board for a maximum of 18 months. During this 18-month period, those plans shall be in good standing with the Department of Managed Health Care and shall demonstrate to the board that they are making a good faith effort to obtain a commercial license with the Department of Managed Health Care. The board may extend this period to 24 months if the board determines the additional time is necessary to comply with this requirement. In their application to the program, those entities shall provide assurance of their standing with the Department of Managed Health Care and shall outline their plans for obtaining commercial licensure.

(d) County organized health systems and the special health care authority established under Section 101675 of the Health and Safety Code that have a contract with the State Department of Health Services, and that contract with the program, and that are not licensed by either the Insurance Commissioner or the Department of Managed Health Care may contract with the board for a maximum of 24 months. During this 24-month period those plans shall be in good standing with the state agency providing oversight to their

operations and shall demonstrate to the board that they are making a good faith effort to obtain licensure with the Department of Insurance or the Department of Managed Health Care. In their application to the program, those entities shall provide assurance of their standing with the appropriate state oversight entity and shall outline their plans for obtaining licensure from the Department of Insurance or the Department of Managed Health Care.

SEC. 74. Section 12693.365 of the Insurance Code is amended to read:

12693.365. Geographic managed care plans that have a contract with the Department of Health Services, that contract with the program, and that are licensed by the Department of Managed Health Care but do not have a commercial license from the Department of Managed Health Care, may contract with the board for a maximum of 12 months. During this 12-month period, those plans shall be required to be in good standing with the Department of Managed Health Care and shall demonstrate to the board that they are making a good faith effort to obtain a commercial license from the Department of Managed Health Care. In their application to the program, those plans shall provide assurance of their standing with the Department of Managed Health Care and shall outline their plans for obtaining commercial licensure.

SEC. 75. Section 12693.37 of the Insurance Code is amended to read:

12693.37. (a) The board shall contract with a broad range of health plans in an area, if available, to ensure that subscribers have a choice from among a reasonable number and types of competing health plans. The board shall develop and make available objective criteria for health plan selection and provide adequate notice of the application process to permit all health plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating health plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this chapter. Health plan selection shall be based on the criteria developed by the board.

(b) (1) In its selection of participating plans the board shall take all reasonable steps to assure the range of choices available to each applicant, other than a purchasing credit member, shall include plans that include in their provider networks and have signed contracts with traditional and safety net providers.

(2) Participating health plans shall be required to submit to the board on an annual basis a report summarizing their provider network. The report shall provide, as available, information on the provider network as it relates to:

(A) Geographic access for the subscribers.

(B) Linguistic services.

(C) The ethnic composition of providers.

(D) The number of subscribers who selected traditional and safety net providers.

(c) (1) The board shall not rely solely on the Department of Managed Health Care's determination of a health plan network's adequacy or geographic access to providers in the awarding of contracts under this part. The board shall collect and review demographic, census, and other data to provide to prospective local initiatives, health plans, or specialized health plans, as defined in this act, specific provider contracting target areas with significant numbers of uninsured children in low-income families. The board shall give priority to those plans, on a county-by-county basis, that demonstrate that they have included in their prospective plan networks significant numbers of providers in these geographic areas.

(2) Targeted contracting areas are those ZIP Codes or groups of ZIP Codes or census tracts or groups of census tracts that have a percentage of uninsured children in low-income families greater than the overall percentage of uninsured children in low-income families in that county.

(d) In each geographic area, the board shall designate a community provider plan that is the participating health plan which has the highest percentage of traditional and safety net providers in its network. Subscribers selecting such a plan shall be given a family contribution discount as described in Section 12693.43.

(e) The board shall establish reasonable limits on health plan administrative costs.

SEC. 76. Section 12695.18 of the Insurance Code is amended to read:

12695.18. ''Participating health plan'' means any of the following plans which are lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the program to provide coverage to program subscribers:

(a) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(b) A nonprofit hospital service plan qualifying under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2.

(c) A nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code).

(d) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.

(e) A county or a city and county, in which case no license or approval from the Department of Insurance or the Department of Managed Health Care shall be required to meet the requirements of this part.

(f) A comprehensive primary care licensed community clinic that is an organized outpatient freestanding health facility and is not part of a hospital that delivers comprehensive primary care services, in which case, no license or approval from the Department of Insurance or the Department of Managed Health Care shall be required to meet the requirements of this part.

SEC. 77. Section 4600.5 of the Labor Code is amended to read:

4600.5. (a) Any health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, a disability insurer licensed by the Department of Insurance, or any entity, including, but not limited to, workers' compensation insurers and third-party administrators authorized by the administrative director under subdivision (e), may make written application to the administrative director to become certified as a health care organization to provide health care to injured employees for injuries and diseases compensable under this article.

(b) Each application for certification shall be accompanied by a reasonable fee prescribed by the administrative director, sufficient to cover the actual cost of processing the application. A certificate is valid for the period that the director may prescribe unless sooner revoked or suspended.

(c) If the health care organization is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, the administrative director shall certify the plan to provide health care pursuant to Section 4600.3 if the director finds that the plan is in good standing with the Department of Managed Health Care and meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Managed Health Care in compliance with the Knox-Keene Health Care Service Plan Act, relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is

providing medical treatment to injured employees in compliance with the requirements of this code.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to Sections 1370 and 1370.1 of the Health and Safety Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(d) If the health care organization is a disability insurer licensed by the Department of Insurance, and is in compliance with subdivision (d) of Sections 10133 and 10133.5 of the Insurance Code, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that the plan is in good standing with the Department of Insurance and meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Insurance in compliance with the Insurance Code relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(e) If the health care organization is a workers' compensation insurer, third-party administrator, or any other entity that the administrative director determines meets the requirements of Section 4600.6, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that it meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records relating to provider accessibility, peer review, utilization review, quality assurance, advertising, disclosure, medical and financial audits, and grievance systems, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(7) Complies with the following requirements:

(A) An organization certified by the administrative director under this subdivision may not provide or undertake to arrange for the provision of health care to employees, or to pay for or to reimburse any part of the cost of that health care in return for a prepaid or periodic charge paid by or on behalf of those employees.

(B) Every organization certified under this subdivision shall operate on a fee-for-service basis. As used in this section, fee for service refers to the situation where the amount of reimbursement paid by the employer to the organization or providers of health care is determined by the amount and type of health care rendered by the organization or provider of health care.

(C) An organization certified under this subdivision is prohibited from assuming risk.

(f) (1) A workers' compensation health care provider organization authorized by the Department of Corporations on December 31, 1997, shall be eligible for certification as a health care organization under subdivision (e).

(2) An entity that had, on December 31, 1997, submitted an application with the Commissioner of Corporations under Part 3.2 (commencing with Section 5150) shall be considered an applicant for certification under subdivision (e) and shall be entitled to priority in consideration of its application. The Commissioner of Corporations shall provide complete files for all pending applications to the administrative director on or before January 31, 1998.

(g) The provisions of this section shall not affect the confidentiality or admission in evidence of a claimant's medical treatment records.

(h) Charges for services arranged for or provided by health care service plans certified by this section and that are paid on a per-enrollee-periodic-charge basis shall not be subject to the schedules adopted by the administrative director pursuant to Section 5307.1.

(i) Nothing in this section shall be construed to expand or constrict any requirements imposed by law on a health care service plan or insurer when operating as other than a health care organization pursuant to this section.

(j) In consultation with interested parties, including the Department of Corporations and the Department of Insurance, the administrative director shall adopt rules necessary to carry out this section.

(k) The administrative director shall refuse to certify or may revoke or suspend the certification of any health care organization under this section if the director finds that:

(1) The plan for providing medical treatment fails to meet the requirements of this section.

(2) A health care service plan licensed by the Department of Managed Health Care, a workers' compensation health care provider organization authorized by the Department of Corporations, or a carrier licensed by the Department of Insurance is not in good standing with its licensing agency.

(3) Services under the plan are not being provided in accordance with the terms of a certified plan.

(*l*) (1) When an injured employee requests chiropractic treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of a chiropractor pursuant to guidelines for chiropractic care established by paragraph (2). Within five working days of the employee's request to see a chiropractor, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated chiropractor for work-related injuries that are within the guidelines for chiropractic care established by paragraph (2). Chiropractic care rendered in accordance with guidelines for chiropractic care established pursuant to paragraph (2) shall be provided by duly licensed chiropractors affiliated with the plan.

(2) The health care organization shall establish guidelines for chiropractic care in consultation with affiliated chiropractors who are participants in the health care organization's utilization review process for chiropractic care, which may include qualified medical evaluators knowledgeable in the treatment of chiropractic conditions. The guidelines for chiropractic care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated chiropractor for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of chiropractic care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for chiropractic care in accordance with the health care organization's guidelines for chiropractic care established by paragraph (2).

Chiropractic utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for chiropractic care. Chiropractors affiliated with the plan shall have access to the health care organization's provider appeals process and, in the case of chiropractic care for work-related injuries, the review shall include review by a chiropractor affiliated with the health care organization, as determined by the health care organization.

(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to chiropractic care, including the location and telephone number where grievances may be submitted.

(5) All guidelines for chiropractic care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.

(m) Individually identifiable medical information on patients submitted to the division shall not be subject to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(n) (1) When an injured employee requests acupuncture treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of an acupuncturist pursuant to guidelines for acupuncture care established by paragraph (2). Within five working days of the employee's request to see an acupuncturist, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated acupuncturist for work-related injuries that are within the guidelines for acupuncture care established by paragraph (2). Acupuncture care rendered in accordance with guidelines for acupuncture care established pursuant to paragraph (2) shall be provided by duly licensed acupuncturists affiliated with the plan.

(2) The health care organization shall establish guidelines for acupuncture care in consultation with affiliated acupuncturists who are participants in the health care organization's utilization review process for acupuncture care, which may include qualified medical evaluators. The guidelines for acupuncture care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated acupuncturist for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of acupuncture care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for acupuncture care in accordance with the health care organization's guidelines for acupuncture care established by paragraph (2).

Acupuncture utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for acupuncture care. Acupuncturists affiliated with the plan shall have access to the health care organization's provider appeals process and, in the case of acupuncture care for work-related injuries, the review shall include review by an acupuncturist affiliated with the health care organization, as determined by the health care organization.

(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to acupuncture care, including the location and telephone number where grievances may be submitted.

(5) All guidelines for acupuncture care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.

SEC. 78. Section 830.3 of the Penal Code is amended to read:

830.3. The following persons are peace officers whose authority extends to any place in the state for the purpose of performing their primary duty or when making an arrest pursuant to Section 836 of the

Penal Code as to any public offense with respect to which there is immediate danger to person or property, or of the escape of the perpetrator of that offense, or pursuant to Section 8597 or 8598 of the Government Code. These peace officers may carry firearms only if authorized and under those terms and conditions as specified by their employing agencies:

(a) Persons employed by the Division of Investigation of the Department of Consumer Affairs and investigators of the Medical Board of California and the Board of Dental Examiners, who are designated by the Director of Consumer Affairs, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 160 of the Business and Professions Code. The Director of Consumer Affairs shall designate as peace officers seven persons who shall at the time of their designation be assigned to the investigations unit of the Board of Dental Examiners.

(b) Voluntary fire wardens designated by the Director of Forestry and Fire Protection pursuant to Section 4156 of the Public Resources Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 4156 of that code.

(c) Employees of the Department of Motor Vehicles designated in Section 1655 of the Vehicle Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 1655 of that code.

(d) Investigators of the California Horse Racing Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of Chapter 4 (commencing with Section 19400) of Division 8 of the Business and Professions Code and Chapter 10 (commencing with Section 330) of Title 9 of Part 1 of this code.

(e) The State Fire Marshal and assistant or deputy state fire marshals appointed pursuant to Section 13103 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 13104 of that code.

(f) Inspectors of the food and drug section designated by the chief pursuant to subdivision (a) of Section 106500 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 106500 of that code.

(g) All investigators of the Division of Labor Standards Enforcement designated by the Labor Commissioner, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Section 95 of the Labor Code.

(h) All investigators of the State Departments of Health Services, Social Services, Mental Health, Developmental Services, and Alcohol

and Drug Programs, the Department of Toxic Substances Control, the Office of Statewide Health Planning and Development, and the Public Employees' Retirement System, provided that the primary duty of these peace officers shall be the enforcement of the law relating to the duties of his or her department, or office. Notwithstanding any other provision of law, investigators of the Public Employees' Retirement System shall not carry firearms.

(i) The Chief of the Bureau of Fraudulent Claims of the Department of Insurance and those investigators designated by the chief, provided that the primary duty of those investigators shall be the enforcement of Section 550.

(j) Employees of the Department of Housing and Community Development designated under Section 18023 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 18023 of that code.

(k) Investigators of the office of the Controller, provided that the primary duty of these investigators shall be the enforcement of the law relating to the duties of that office. Notwithstanding any other law, except as authorized by the Controller, the peace officers designated pursuant to this subdivision shall not carry firearms.

(*l*) Investigators of the Department of Corporations designated by the Commissioner of Corporations, provided that the primary duty of these investigators shall be the enforcement of the provisions of law administered by the Department of Corporations. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(m) Persons employed by the Contractors' State License Board designated by the Director of Consumer Affairs pursuant to Section 7011.5 of the Business and Professions Code, provided that the primary duty of these persons shall be the enforcement of the law as that duty is set forth in Section 7011.5, and in Chapter 9 (commencing with Section 7000) of Division 3, of that code. The Director of Consumer Affairs may designate as peace officers not more than three persons who shall at the time of their designation be assigned to the special investigations unit of the board. Notwithstanding any other provision of law, the persons designated pursuant to this subdivision shall not carry firearms.

(n) The chief and coordinators of the Law Enforcement Division of the Office of Emergency Services.

(o) Investigators of the office of the Secretary of State designated by the Secretary of State, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Chapter 3 (commencing with Section 8200) of Division 1 of Title 2 of, and Section 12172.5 of, the Government Code. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(p) The Deputy Director for Security designated by Section 8880.38 of the Government Code, and all lottery security personnel assigned to the California State Lottery and designated by the director, provided that the primary duty of any of those peace officers shall be the enforcement of the laws related to assuring the integrity, honesty, and fairness of the operation and administration of the California State Lottery.

(q) Investigators employed by the Investigation Division of the Employment Development Department designated by the director of the department, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 317 of the Unemployment Insurance Code.

Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(r) The chief and assistant chief of museum security and safety of the California Science Center, as designated by the executive director pursuant to Section 4108 of the Food and Agricultural Code, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 4108 of the Food and Agricultural Code.

(s) Employees of the Franchise Tax Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of the law as set forth in Chapter 9 (commencing with Section 19701) of Part 10.2 of Division 2 of the Revenue and Taxation Code.

(t) Notwithstanding any other provision of this section, a peace officer authorized by this section shall not be authorized to carry firearms by his or her employing agency until that agency has adopted a policy on the use of deadly force by those peace officers, and until those peace officers have been instructed in the employing agency's policy on the use of deadly force.

Every peace officer authorized pursuant to this section to carry firearms by his or her employing agency shall qualify in the use of the firearms at least every six months.

(u) Investigators of the Department of Managed Health Care designated by the Director of the Department of Managed Health Care, provided that the primary duty of these investigators shall be the enforcement of the provisions of laws administered by the Director of the Department of Managed Health Care. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

SEC. 79. Section 5777 of the Welfare and Institutions Code is amended to read:

5777. (a) (1) Except as otherwise specified in this part, a contract entered into pursuant to this part shall include a provision that the mental health plan contractor shall bear the financial risk for the cost of providing medically necessary mental health services to

Medi-Cal beneficiaries irrespective of whether the cost of those services exceeds the payment set forth in the contract. If the expenditures for services do not exceed the payment set forth in the contract, the mental health plan contractor shall report the unexpended amount to the department, but shall not be required to return the excess to the department.

(2) If the mental health plan is not the county's, the mental health plan may not transfer the obligation for any mental health services to Medi-Cal beneficiaries to the county. The mental health plan may purchase services from the county. The mental health plan shall establish mutually agreed-upon protocols with the county that clearly establish conditions under which beneficiaries may obtain non-Medi-Cal reimbursable services from the county. Additionally, the plan shall establish mutually agreed-upon protocols with the county for the conditions of transfer of beneficiaries who have lost Medi-Cal eligibility to the county for care under Part 2 (commencing with Section 5600), Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850).

(3) The mental health plan shall be financially responsible for ensuring access and a minimum required scope of benefits, consistent with state and federal requirements, to the services to the Medi-Cal beneficiaries of that county regardless of where the beneficiary resides. The department shall require that the definition of medical necessity used, and the minimum scope of benefits offered, by each mental health contractor be the same, except to the extent that any variations receive prior federal approval and are consistent with state and federal statutes and regulation.

(b) Any contract entered into pursuant to this part may be renewed if the plan continues to meet the requirements of this part, regulations promulgated pursuant thereto, and the terms and conditions of the contract. Contract renewal shall be on an annual basis. Failure to meet these requirements shall be cause for nonrenewal of the contract. The department may base the decision to renew on timely completion of a mutually agreed upon plan of correction of any deficiencies, submissions of required information in a timely manner, or other conditions of the contract.

(c) (1) The obligations of the mental health plan shall be changed only by contract or contract amendment.

(2) A change may be made during a contract term or at the time of contract renewal, where there is a change in obligations required by federal or state law or when required by a change in the interpretation or implementation of any law or regulation. To the extent permitted by federal law and except as provided under subdivision (r) of Section 5778, if any change in obligations occurs that affects the cost to the mental health plan of performing under the terms of its contract, the department may reopen contracts to negotiate the state General Fund allocation to the mental health plan

under Section 5778, if the mental health plan is reimbursed through a fee-for-service payment system, or the capitation rate to the mental health plan under Section 5779, if the mental health plan is reimbursed through a capitated rate payment system. During the time period required to redetermine the allocation or rate, payment to the mental health plan of the allocation or rate in effect at the time the change occurred shall be considered interim payments and shall be subject to increase or decrease, as the case may be, effective as of the date on which the change is effective.

(3) To the extent permitted by federal law, either the department or the mental health plan may request that contract negotiations be reopened during the course of a contract due to substantial changes in the cost of covered benefits that result from an unanticipated event.

(d) The department shall immediately terminate a contract when the director finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries. Termination of the contract for other reasons shall be subject to reasonable notice of the department's intent to take that action and notification of affected beneficiaries. The plan may request a public hearing by the Office of Administrative Hearings.

(e) A plan may terminate its contract in accordance with the provisions in the contract. The plan shall provide written notice to the department at least 180 days prior to the termination or nonrenewal of the contract.

(f) Upon the request of the Director of Mental Health, the Director of the Department of Managed Health Care may exempt a mental health plan contractor or a capitated rate contract from the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). These exemptions may be subject to conditions the director deems appropriate. Nothing in this part shall be construed to impair or diminish the authority of the Director of the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in this part be construed to reduce or otherwise limit the obligation of a mental health plan contractor licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder. The Director of Mental Health, in consultation with the Director of the Department of Managed Health Care, shall analyze the appropriateness of licensure or application of applicable standards of the Knox-Keene Health Care Service Plan Act of 1975.

(g) The department, pursuant to an agreement with the State Department of Health Services, shall provide oversight to the mental health plans to ensure quality, access, and cost efficiency. At a

minimum, the department shall, through a method independent of any agency of the mental health plan contractor, monitor the level and quality of services provided, expenditures pursuant to the contract, and conformity with federal and state law.

(h) County employees implementing or administering a mental health plan act in a discretionary capacity when they determine whether or not to admit a person for care or to provide any level of care pursuant to this part.

(i) If a county chooses to discontinue operations as the local mental health plan, the new plan shall give reasonable consideration to affiliation with nonprofit community mental health agencies that were under contract with the county and that meet the mental health plan's quality and cost efficiency standards.

(j) Nothing in this part shall be construed to modify, alter, or increase the obligations of counties as otherwise limited and defined in Chapter 3 (commencing with Section 5700) of Part 2. The county's maximum obligation for services to persons not eligible for Medi-Cal shall be no more than the amount of funds remaining in the mental health subaccount pursuant to Sections 17600, 17601, 17604, 17605, 17606, and 17609 after fulfilling the Medi-Cal contract obligations.

SEC. 80. Section 9541 of the Welfare and Institutions Code is amended to read:

9541. (a) The Legislature finds and declares that the purpose of the Health Insurance Counseling and Advocacy Program is to provide Medicare beneficiaries and those imminent of becoming eligible for Medicare with counseling and advocacy as to Medicare, private health insurance, and related health care coverage plans, on a statewide basis, and preserving service integrity.

(b) The department shall be responsible for, but not limited to, doing both of the following:

(1) To act as a clearinghouse for information and materials relating to Medicare, managed care, health and long-term care related life and disability insurance, and related health care coverage plans.

(2) To develop additional information and materials relating to Medicare, managed care, and health and long-term care related life and disability insurance, and related health care coverage plans, as necessary.

(c) Notwithstanding the terms and conditions of the contracts, direct services contractors shall be responsible for, but not limited to, all of the following:

(1) Community education to the public on Medicare, long-term care planning, private health and long-term care insurance, managed care, and related health care coverage plans.

(2) Counseling and informal advocacy with respect to Medicare, long-term care planning, private health and long-term care insurance, managed care, and related health care coverage plans.

(3) Referral services for legal representation or legal representation with respect to Medicare appeals, Medicare related managed care appeals, and life and disability insurance problems. Legal services provided under this program shall be subject to the understanding that the legal representation and legal advocacy shall not include the filing of lawsuits against private insurers or managed health care plans. In the event that legal services are contracted for by the agency separately from counseling and education services, a formal system of coordination and referral from counseling services to legal services shall be established and maintained.

(4) Educational services supporting long-term care educational activities aimed at the general public, employers, employee groups, senior organizations, and other groups expressing interest in long-term care planning issues.

(5) Educational services emphasizing the importance of long-term care planning, promotion of self-reliance and independence, and options for long-term care.

(6) To the extent possible, support additional emphasis on community educational activities that would provide for announcements on television and in other media describing the limited nature of Medicare, the need for long-term care planning, the function of long-term care insurance, and the availability of counseling and educational literature on those subjects.

(7) Recruitment, training, coordination, and registration, with the department, of health insurance counselors, including a large contingent of volunteer counselors designed to expand services as broadly as possible.

(8) A systematic means of capturing and reporting all required community-based services program data, as specified by the department.

(d) Participants who volunteer their time for the health insurance counseling and advocacy program may be reimbursed for expenses incurred, as specified by the department.

(e) The department, the Department of Managed Health Care, and the Department of Insurance shall jointly develop interagency procedures for referring and investigating suspected instances of misrepresentation in advertising or sales of services provided by Medicare, managed health care plans, and life and disability insurers and agents.

(f) (1) No health insurance counselor shall provide counseling services under this chapter, unless he or she is registered with the department.

(2) No registered volunteer health insurance counselor shall be liable for his or her negligent act or omission in providing counseling services under this chapter. No immunity shall apply to health insurance counselors for any grossly negligent act or omission or intentional misconduct.

(3) No registered volunteer health insurance counselor shall be liable to any insurance agent, broker, employee thereof, or similarly situated person, for defamation, trade libel, slander, or similar actions based on statements made by the counselor when providing counseling, unless a statement was made with actual malice.

(4) Prior to providing any counseling services, health insurance counselors shall disclose, in writing, to recipients of counseling services pursuant to this chapter that the counselors are acting in good faith to provide information about health insurance policies and benefits on a volunteer basis, but that the information shall not be construed to be legal advice, and that the counselors are, generally, not liable unless their acts and omissions are grossly negligent or there is intentional misconduct on the part of the counselor.

(5) The department shall not register any applicant under this section unless he or she has completed satisfactorily training which is approved by the department, and which shall consist of not less than 24 hours of training that shall include, but is not limited to, all of the following subjects:

(A) Medicare.

(B) Life and disability insurance.

(C) Managed care.

(D) Retirement benefits and principles of long-term care planning.

(E) Counseling skills.

(F) Any other subject or subjects determined by the department to be necessary to the provision of counseling services under this chapter.

(6) The department shall not register any applicant under this section unless he or she has completed all training requirements and has served an internship of cocounseling of not less than 10 hours with an experienced counselor and is determined by the local program manager to be capable of discharging the responsibilities of a counselor. An applicant shall sign a conflict of interest and confidentiality agreement, as specified by the department.

(7) A counselor shall not continue to provide health insurance counseling services unless he or she has received continuing education and training, in a manner prescribed by the department, on Medicare, managed care, life and disability insurance, and other subjects during each calendar year.

SEC. 81. Section 14087.32 of the Welfare and Institutions Code is amended to read:

14087.32. (a) Commencing on the date the authority first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until a commission established pursuant to Section 14087.31 is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under Chapter 2.2 (commencing with

Section 1340) of Division 2 of the Health and Safety Code, all of the following shall apply:

(1) The commission may select and design its automated management information system. The department, in cooperation with the commission, prior to making capitated payments, shall test the system to ensure that the system is capable of producing detailed, accurate, and timely financial information on the financial condition of the commission, and any other information that is generally required by the department in its contracts with other health care service plans.

(2) In addition to the reports required by the Department of Managed Health Care under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, a commission established pursuant to Section 14087.31 shall provide, on a monthly basis, to the department, the Department of Managed Health Care, and the members of the commission, a copy of the automated report described in paragraph (1) and a projection of assets and liabilities, including those that have been incurred but not reported, with an explanation of material increases or decreases in current or projected assets of liabilities. The explanation of increases and decreases in assets or liabilities shall be provided, upon request, to a hospital, independent physicians' practice association or community clinic, which has contracted with the authority to provide health care services.

(3) In addition to the reporting and notification obligations the commission has under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, the chief executive officer or director of the commission shall immediately notify the department, the Department of Managed Health Care, and the members of the commission, in writing, of any fact or facts that, in the chief executive officer's or director's reasonable and prudent judgment, is likely to result in the commission being unable to meet its financial obligations to health care providers or to other parties. The written notice shall describe the fact or facts, the anticipated fiscal consequences, and the actions which will be taken to address the anticipated consequences.

(4) The Department of Managed Health Care shall not, in any way, waive or vary, nor shall the department request the Department of Managed Health Care to waive or vary, the tangible net equity requirements for a commission under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, after three years from the date of commencement of capitated payments to the commission. Until the commission is in compliance with all of the tangible net equity requirements under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the rules of the Director of the

Department of Managed Health Care adopted thereunder, the commission shall develop a stop-loss program appropriate to the risks of the commission, which program shall be satisfactory to both department and the Department of Managed Health Care.

(5) (A) If the commission votes to file a petition of bankruptcy, or the county board of supervisors notifies the department of its intent to terminate the commission, the department shall immediately transfer the authority's Medi-Cal beneficiaries as follows:

(i) To other managed care contractors, when available, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees.

(ii) To the extent that other managed care contractors are unavailable or the department determines that it is otherwise in the best interest of any particular beneficiary, to a fee-for-service reimbursement system pending the availability of managed care contractors provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees, or the department determines that providing care to any particular beneficiary pursuant to a fee-for-service reimbursement system is no longer necessary to protect the continuity of care or other interests of the beneficiary.

(B) Beneficiary eligibility for Medi-Cal shall not be affected by actions taken pursuant to subparagraph (A).

(C) Beneficiaries who have been or who are scheduled to be transferred to a fee-for-service reimbursement system or managed care contractor may make a choice to be enrolled in another managed care system, if one is available, in full compliance with the federal freedom-of-choice requirements.

(6) (A) A commission established pursuant to Section 14087.31 shall submit to a review of financial records when the department determines, based on data reported by the commission or otherwise, that the commission will not be able to meet its financial obligations to health care providers contracting with the commission. Where the review of financial records determines that the commission will not be able to meet its financial obligations to contracting health care providers for the provision of health care services, the Director of Health Services shall immediately terminate the contract between the commission and the state, and immediately transfer the commission's Medi-Cal beneficiaries in accordance with paragraph (5) in order to ensure uninterrupted provision of health care services to the beneficiaries and to minimize financial disruption to providers.

(B) The action of the Director of Health Services pursuant to subparagraph (A) shall be the final administrative determination.

Beneficiary eligibility for Medi-Cal shall not be affected by this action.

(C) Beneficiaries who have been or who are scheduled to be transferred under paragraph (5) may make a choice to be enrolled in another managed care plan, if one is available, in full compliance with federal freedom-of-choice requirements.

(7) It is the intent of the Legislature that the department shall implement Medi-Cal capitated enrollments in a matter that ensures that appropriate levels of health care services will be provided to Medi-Cal beneficiaries and that appropriate levels of administrative services will be furnished to health care providers. The contract between the department and the commission shall authorize and permit the department to administer the number of covered Medi-Cal enrollments in such a manner that the commission's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(8) In the event a commission is terminated, files for bankruptcy, or otherwise no longer functions for the purpose for which it was established, the county shall, with respect to compensation for provision of health care services to beneficiaries, occupy no greater or lesser status than any other health care provider in the disbursement of assets of the commission.

(9) Nothing in this section shall be construed to impair or diminish the authority of the Director of the Department Managed Health Care under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, nor shall anything in the section be construed to reduce or otherwise limit the obligation of a commission licensed as a health care service plan to comply with the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code and the rules of the Director of the Department of Managed Health Care adopted thereunder.

(10) Except as expressly provided by other provisions of this section, all exemptions and exclusions from disclosure as public records pursuant to the Public Records Act (Chapter 5 (commencing with Section 65250) of Division 7 of Title 1 of the Government Code), including but not limited to, those pertaining to trade secrets and information withheld in the public interest, shall be fully applicable for all state agencies and local agencies with respect to all writings that the commission is required to prepare, produce or submit pursuant to this section.

SEC. 82. Section 14087.36 of the Welfare and Institutions Code is amended to read:

14087.36. (a) The following definitions shall apply for purposes of this section:

(1) ''County'' means the City and County of San Francisco.

(2) ‘‘Board’’ means the Board of Supervisors of the City and County of San Francisco.

(3) ‘‘Department’’ means the State Department of Health Services.

(4) ‘‘Governing body’’ means the governing body of the health authority.

(5) ‘‘Health authority’’ means the separate public agency established by the board of supervisors to operate a health care system in the county and to engage in the other activities authorized by this section.

(b) The Legislature finds and declares that it is necessary that a health authority be established in the county to arrange for the provision of health care services in order to meet the problems of the delivery of publicly assisted medical care in the county, to enter into a contract with the department under Article 2.97 (commencing with Section 14093), or to contract with a health care service plan on terms and conditions acceptable to the department, and to demonstrate ways of promoting quality care and cost efficiency.

(c) The county may, by resolution or ordinance, establish a health authority to act as and be the local initiative component of the Medi-Cal state plan pursuant to regulations adopted by the department. If the board elects to establish a health authority, all rights, powers, duties, privileges, and immunities vested in a county under Article 2.8 (commencing with Section 14087.5) and Article 2.97 (commencing with Section 14093) shall be vested in the health authority. The health authority shall have all power necessary and appropriate to operate programs involving health care services, including, but not limited to, the power to acquire, possess, and dispose of real or personal property, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to take all actions and engage in all public and private business activities, subject to any applicable licensure, as permitted a health care service plan pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(d) (1) (A) The health authority shall be considered a public entity separate and distinct from the county and shall file the statement required by Section 53051 of the Government Code. The health authority shall have primary responsibility to provide the defense and indemnification required under Division 3.6 (commencing with Section 810) of Title 1 of the Government Code for employees of the health authority who are employees of the county. The health authority shall provide insurance under terms and conditions required by the county in order to satisfy its obligations under this section.

(B) For purposes of this paragraph, ‘‘employee’’ shall have the same meaning as set forth in Section 810.2 of the Government Code.

(2) The health authority shall not be considered to be an agency, division, department, or instrumentality of the county and shall not be subject to the personnel, procurement, or other operational rules of the county.

(3) Notwithstanding any other provision of law, any obligations of the health authority, statutory, contractual, or otherwise, shall be the obligations solely of the health authority and shall not be the obligations of the county, unless expressly provided for in a contract between the authority and the county, nor of the state.

(4) Except as agreed to by contract with the county, no liability of the health authority shall become an obligation of the county upon either termination of the health authority or the liquidation or disposition of the health authority's remaining assets.

(e) (1) To the full extent permitted by federal law, the department and the health authority may enter into contracts to provide or arrange for health care services for any or all persons who are eligible to receive benefits under the Medi-Cal program. The contracts may be on an exclusive or nonexclusive basis, and shall include payment provisions on any basis negotiated between the department and the health authority. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter 18 (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, individuals employed by public agencies and private businesses, and uninsured or indigent individuals.

(2) Notwithstanding paragraph (1), or subdivision (f), the health authority may not operate health plans or programs for individuals covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, or for private businesses, until the health authority is in full compliance with all of the requirements of the Knox-Keene Health Care Service Plan Act of 1975 under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, including tangible net equity requirements applicable to a licensed health care service plan. This limitation shall not preclude the health authority from enrolling persons pursuant to the county's obligations under Section 17000, or from enrolling county employees.

(f) The board of supervisors may transfer responsibility for administration of county-provided health care services to the health authority for the purpose of service of populations including uninsured and indigent persons, subject to the provisions of any ordinances or resolutions passed by the county board of supervisors. The transfer of administrative responsibility for those health care services shall not relieve the county of its responsibility for indigent care pursuant to Section 17000. The health authority may also enter into contracts for the provision of health care services to individuals

including, but not limited to, those covered under Subchapter 18 (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, and individuals employed by public agencies and private businesses.

(g) Upon creation, the health authority may borrow from the county and the county may lend the authority funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations or perform the activities of the health authority. Notwithstanding any other provision of law, both the county and the health authority shall be eligible to receive funding under subdivision (p) of Section 14163.

(h) The county may terminate the health authority, but only by an ordinance approved by a two-thirds affirmative vote of the full board.

(i) Prior to the termination of the health authority, the county shall notify the department of its intent to terminate the health authority. The department shall conduct an audit of the health authority's records within 30 days of notification to determine the liabilities and assets of the health authority. The department shall report its findings to the county and to the Department of Managed Health Care within 10 days of completion of the audit. The county shall prepare a plan to liquidate or otherwise dispose of the assets of the health authority and to pay the liabilities of the health authority to the extent of the health authority's assets, and present the plan to the department and the Department of Managed Health Care within 30 days upon receipt of these findings.

(j) Any assets of the health authority derived from the contract entered into between the state and the authority pursuant to Article 2.97 (commencing with Section 14093), after payment of the liabilities of the health authority, shall be disposed of pursuant to the contract.

(k) (1) The governing body shall consist of 18 voting members, 14 of whom shall be appointed by resolution or ordinance of the board as follows:

(A) One member shall be a member of the board or any other person designated by the board.

(B) One member shall be a person who is employed in the senior management of a hospital not operated by the county or the University of California and who is nominated by the San Francisco Section of the Westbay Hospital Conference or any successor organization, or if no such successor organization, a person who shall be nominated by the Hospital Council of Northern and Central California.

(C) Two members, one of whom shall be a person employed in the senior management of San Francisco General Hospital and one of whom shall be a person employed in the senior management of St. Luke's Hospital (San Francisco). If San Francisco General Hospital

or St. Luke's Hospital, at the end of the term of the person appointed from its senior management, is not designated as a disproportionate share hospital, and if the governing body, after providing an opportunity for comment by the Westbay Hospital Conference, or any successor organization, determines that the hospital no longer serves an equivalent patient population, the governing body may, by a two-thirds vote of the full governing body, select an alternative hospital to nominate a person employed in its senior management to serve on the governing body. Alternatively, the governing body may approve a reduction in the number of positions on the governing body as set forth in subdivision (p).

(D) Two members shall be employees in the senior management of either private nonprofit community clinics or a community clinic consortium, nominated by the San Francisco Community Clinic Consortium, or any successor organization.

(E) Two members shall be physicians, nominated by the San Francisco Medical Society, or any successor organization.

(F) One member shall be nominated by the San Francisco Labor Council, or any successor organization.

(G) Two members shall be persons nominated by the beneficiary committee of the health authority, at least one of whom shall, at the time of appointment and during the person's term, be a Medi-Cal beneficiary.

(H) Two members shall be persons knowledgeable in matters relating to either traditional safety net providers, health care organizations, the Medi-Cal program, or the activities of the health authority, nominated by the program committee of the health authority.

(I) One member shall be a person nominated by the San Francisco Pharmacy Leadership Group, or any successor organization.

(2) One member, selected to fulfill the appointments specified in subparagraph (A), (G), or (H) shall, in addition to representing his or her specified organization or employer, represent the discipline of nursing, and shall possess or be qualified to possess a registered nursing license.

(3) The initial members appointed by the board under the subdivision shall be, to the extent those individuals meet the qualifications set forth in this subdivision and are willing to serve, those persons who are members of the steering committee created by the county to develop the local initiative component of the Medi-Cal state plan in San Francisco. Following the initial staggering of terms, each of those members shall be appointed to a term of three years, except the member appointed pursuant to subparagraph (A) of paragraph (1), who shall serve at the pleasure of the board. At the first meeting of the governing body, the members appointed pursuant to this subdivision shall draw lots to determine seven members whose initial terms shall be for two years. Each member

shall remain in office at the conclusion of that member's term until a successor member has been nominated and appointed.

(*l*) In addition to the requirements of subdivision (k), one member of the governing body shall be appointed by the Mayor of the City of San Francisco to serve at the pleasure of the mayor, one member shall be the county's director of public health or designee, who shall serve at the pleasure of that director, one member shall be the Chancellor of the University of California at San Francisco or his or her designee, who shall serve at the pleasure of the chancellor, and one member shall be the county director of mental health or his or her designee, who shall serve at the pleasure of that director.

(m) There shall be one nonvoting member of the governing body who shall be appointed by, and serve at the pleasure of, the health commission of the county.

(n) Each person appointed to the governing body shall, throughout the member's term, either be a resident of the county or be employed within the geographic boundaries of the county.

(o) (1) The composition of the governing body and nomination process for appointment of its members shall be subject to alteration upon a two-thirds vote of the full membership of the governing body. This action shall be concurred in by a resolution or ordinance of the county.

(2) Notwithstanding paragraph (1), no alteration described in that paragraph shall cause the removal of a member prior to the expiration of that member's term.

(p) A majority of the members of the governing body shall constitute a quorum for the transaction of business, and all official acts of the governing body shall require the affirmative vote of a majority of the members present and voting. However, no official shall be approved with less than the affirmative vote of six members of the governing body, unless the number of members prohibited from voting because of conflicts of interest precludes adequate participation in the vote. The governing body may, by a two-thirds vote adopt, amend, or repeal rules and procedures for the governing body. Those rules and procedures may require that certain decisions be made by a vote that is greater than a majority vote.

(q) For purposes of Section 87103 of the Government Code, members appointed pursuant to subparagraphs (B) to (E), inclusive, of paragraph (1) of subdivision (k) represent, and are appointed to represent, respectively, the hospitals, private nonprofit community clinics, and physicians that contract with the health authority, or the health care service plan with which the health authority contracts, to provide health care services to the enrollees of the health authority or the health care service plan. Members appointed pursuant to subparagraphs (F) and (G) of paragraph (1) of subdivision (k) represent and are appointed to represent, respectively, the health care workers and enrollees served by the health authority or its

contracted health care service plan, and traditional safety net and ancillary providers and other organizations concerned with the activities of the health authority.

(r) A member of the governing body may be removed from office by the board by resolution or ordinance, only upon the recommendation of the health authority, and for the following reasons:

(1) Failure to retain the qualifications for appointment specified in subdivisions (k) and (n).

(2) Death or a disability that substantially interferes with the member's ability to carry out the duties of office.

(3) Conviction of any felony or a crime involving corruption.

(4) Failure of the member to discharge legal obligations as a member of a public agency.

(5) Substantial failure to perform the duties of office, including, but not limited to, unreasonable absence from meetings. The failure to attend three meetings in a row of the governing body, or a majority of the meetings in the most recent calendar year, may be deemed to be unreasonable absence.

(s) Any vacancy on the governing body, however created, shall be filled for the unexpired term by the board by resolution or ordinance. Each vacancy shall be filled by an individual having the qualifications of his or her predecessor, nominated as set forth in subdivision (k).

(t) The chair of the authority shall be selected by, and serve at the pleasure of, the governing body.

(u) The health authority shall establish all of the following:

(1) A beneficiary committee to advise the health authority on issues of concern to the recipients of services.

(2) A program committee to advise the health authority on matters relating to traditional safety net providers, ancillary providers, and other organizations concerned with the activities of the health authority.

(3) Any other committees determined to be advisable by the health authority.

(v) (1) Notwithstanding any provision of state or local law, including, but not limited to, the county charter, a member of the health authority shall not be deemed to be interested in a contract entered into by the authority within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code, or within the meaning of conflict-of-interest restrictions in the county charter, if all of the following apply:

(A) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(B) The member discloses the interest to the health authority and abstains from voting on the contract.

(C) The health authority notes the member's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(D) The member has an interest in or was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(E) The contract authorizes the member or the organization the member has an interest in or represents to provide services to beneficiaries under the authority's program or administrative services to the authority.

(2) In addition, no person serving as a member of the governing body shall, by virtue of that membership, be deemed to be engaged in activities that are inconsistent, incompatible, or in conflict with their duties as an officer or employee of the county or the University of California, or as an officer or an employee of any private hospital, clinic, or other health care organization. The membership shall not be deemed to be in violation of Section 1126 of the Government Code.

(w) Notwithstanding any other provision of law, those records of the health authority and of the health county that reveal the authority's rates of payment for health care services or the health authority's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services for rates of payment, or the health authority's peer review proceedings shall not be required to be disclosed pursuant to the California Public Records Act, Chapter 5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, or any similar local law requiring the disclosure of public records. However, three years after a contract or amendment to a contract is fully executed, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(x) Notwithstanding any other provision of law, the health authority may meet in closed session to consider and take action on peer review proceedings and on matters pertaining to contracts and to contract negotiations by the health authority's staff with providers of health care services concerning all matters relating to rates of payment. However, a decision as to whether to enter into, amend the services provisions of, or terminate, other than for reasons based upon peer review, a contract with a provider of health care services, shall be made in open session.

(y) The health authority shall be deemed to be a public agency for purposes of all grant programs and other funding and loan guarantee programs.

(z) Contracts under this article between the State Department of Health Services and the health authority shall be on a nonbid basis

and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(aa) (1) The county controller or his or her designee, at intervals the county controller deems appropriate, shall conduct a review of the fiscal condition of the health authority, shall report the findings to the health authority and the board, and shall provide a copy of the findings to any public agency upon request.

(2) Upon the written request of the county controller, the health authority shall provide full access to the county controller all health authority records and documents as necessary to allow the county controller or designee to perform the activities authorized by this subdivision.

(bb) A Medi-Cal recipient receiving services through the health authority shall be deemed to be a subscriber or enrollee for purposes of Section 1379 of the Health and Safety Code.

SEC. 83. Section 14087.37 of the Welfare and Institutions Code is amended to read:

14087.37. Commencing on the date that a health authority established pursuant to Section 14087.35 or 14087.36 first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until the time that the health authority is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975, the following provisions shall apply:

(a) The health authority may select and design its automated management information system, but the department, in cooperation with the health authority, prior to making capitated payments shall test the system to ensure that the system is capable of producing detailed, accurate, and timely financial information on the financial condition of the health authority and any other information generally required by the department in its contracts with health care service plans.

(b) In addition to the reports required by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, the health authority shall provide on a monthly basis to the department, the Department of Managed Health Care, and the members of the health authority, a copy of the automated report described in subdivision (a) and a projection of assets and liabilities, including those that have been incurred but not reported, with an explanation of material increases or decreases in current or projected assets or liabilities. The explanation of increases and decreases in assets or liabilities shall be provided, upon request, to a hospital, independent physicians' practice association, or community clinic, that has contracted with the health authority to provide health care services.

(c) In addition to the reporting and notification obligations the health authority has under the Knox-Keene Health Care Service Plan Act of 1975, the chief executive officer or director of the health authority shall immediately notify the department, the Department of Managed Health Care, and the members of the health authority in writing of any fact or facts that, in the chief executive officers' or director's reasonable and prudent judgment, is likely to result in the health authority being unable to meet its financial obligations to health care providers or to other parties. Written notice shall describe the fact or facts, the anticipated fiscal consequences, and the actions that will be taken to address the anticipated consequences.

(d) The Department of Managed Health Care shall not waive or vary, nor shall the department request the Department of Managed Health Care to waive or vary, the tangible net equity requirements for a health authority under the Knox-Keene Health Care Service Plan Act of 1975 after three years from the date of commencement of capitated payments to the health authority. Until the time the health authority is in compliance with all of the tangible net equity requirements under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, the health authority shall develop a stop-loss program appropriate to the risks of the health authority. The program shall be satisfactory to both the department and the Department of Managed Health Care.

(e) In the event that the health authority votes to file a petition of bankruptcy, or the board of supervisors notifies the department of its intent to terminate the health authority, the department shall immediately convert the health authority's Medi-Cal beneficiaries to either of the following:

(1) To other managed care contractors when available, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees.

(2) To the extent that other managed care contractors are unavailable or the department determines that the action is otherwise in the best interest of any particular beneficiary, to a fee-for-service reimbursement system pending the availability of managed care contractors, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees, or if the department determines that providing care to any particular beneficiary pursuant to a fee-for-service reimbursement system is no longer necessary to protect the continuity of care or other interests of the beneficiary. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted to a fee-for-service reimbursement system or managed care contractor may make a

choice to be enrolled in another managed care system, if one is available, in full compliance with the federal freedom-of-choice requirements.

(f) The health authority shall submit to a review of financial records when the department determines, based on data reported by the health authority or otherwise, that the health authority will not be able to meet its financial obligations to health care providers contracting with the health authority. Where the review of financial records determines that the health authority will not be able to meet its financial obligations to contracting health care providers for the provision of health care services, the director shall immediately terminate the contract between the health authority and the state, and immediately convert the health authority Medi-Cal beneficiaries in accordance with subdivision (e) in order to ensure uninterrupted provision of health care services to the beneficiaries and to minimize financial disruption to providers. The action of the director shall be the final administrative determination. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted under subdivision (e) may make a choice to be enrolled in another managed care plan, if one is available, in full compliance with federal freedom-of-choice requirements.

(g) It is the intent of the Legislature that the department shall implement Medi-Cal capitated enrollments in a manner that ensures that appropriate levels of health care services will be provided to Medi-Cal beneficiaries and that appropriate levels of administrative services will be furnished to health care providers. The contract between the department and the health authority shall authorize and permit the department to administer the number of covered Medi-Cal enrollments in such a manner that the health authority's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(h) In the event a health authority is terminated, files for bankruptcy, or otherwise no longer functions for the purpose for which it was established, the county shall, with respect to compensation for provision of health care services to beneficiaries, occupy no greater or lesser status than any other health care provider in the disbursement of assets of the health authority.

(i) Nothing in this subdivision shall be construed to impair or diminish the authority of the Director of the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in the section be construed to reduce or otherwise limit the obligation of a health authority licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of

the Director of the Department of Managed Health Care promulgated thereunder.

SEC. 84. Section 14087.38 of the Welfare and Institutions Code is amended to read:

14087.38. (a) (1) In counties selected by the director with the concurrence of the county, a special county health authority may be established in order to meet the problems of delivery of publicly assisted medical care in each county, and to demonstrate ways of promoting quality care and cost efficiency. Nothing in this section shall be construed to preclude the department from expanding Medi-Cal managed care in ways other than those provided for in this section, including, but not limited to, the establishment of a public benefit corporation as set forth in Section 5110 of the Corporations Code.

(2) For purposes of this section ''health authority'' means an entity separate from the county that meets the requirements of state and federal law and the quality, cost, and access criteria established by the department.

(b) The board of supervisors of a county described in subdivision (a) may, by ordinance, establish a health authority to negotiate and enter into contracts authorized by Section 14087.3, and to arrange for the provision of health care services provided pursuant to this chapter. If the board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county contracting with the department under this article shall be vested in the health authority. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, those entitled to coverage under other publicly supported programs, those employed by public agencies or private businesses, and uninsured or indigent individuals.

(c) The enabling ordinance shall specify the membership of the governing board of the health authority, the qualifications for individual members, the manner of appointment, selection, or removal of board members, and how long they shall serve, and any other matters the board of supervisors deems necessary or convenient for the conduct of the health authority's activities. Members of the governing board shall be appointed by the board of supervisors to represent the interests of the county, the general public, beneficiaries, physicians, hospitals, clinics, and other nonphysician health care providers. The health authority so established shall be considered an entity separate from the county, shall file a statement required by Section 53051 of the Government Code, and shall have the power to acquire, possess, and dispose of real or personal property, as necessary for the performance of its functions, to employ personnel and contract for services required to

meet its obligations, and to sue or be sued. Any obligations of a health authority, statutory, contractual, or otherwise, shall be obligations solely of the health authority and shall not be the obligations of the county or of the state.

(d) Upon creation, the health authority may borrow from the county, and the county may lend the health authority funds or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(e) Notwithstanding any other provision of law, both the county and the health authority shall be eligible to receive funding under subdivision (p) of Section 14163, and the health authority shall be considered to have satisfied the requirements of that subdivision.

(f) The health authority shall be deemed to be a public agency that is a unit of local government for purposes of all grant programs and other funding and loan guarantee programs.

(g) It is the intent of the Legislature that if a health authority is formed pursuant to this section, the county shall, with respect to its medical facilities and programs, occupy no greater or lesser status than any other health care provider in negotiating with the health authority for contracts to provide health care services. Nothing in this subdivision shall be construed to interfere with or limit the health authority in giving preference in negotiating to disproportionate share hospitals or other providers of health care to medically indigent or uninsured individuals.

(h) Notwithstanding any other provisions of law, a member of the governing board of the health authority shall not be deemed to be interested in a contract entered into by the health authority within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if all the following apply:

(1) The member was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations, or beneficiaries.

(2) The contract authorizes the member or the organization the member represents to provide services to beneficiaries under the health authority's programs.

(3) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the member was appointed to represent.

(4) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(5) The member discloses the interest to the health authority and abstains from voting on the contract.

(6) The governing board notes the member's disclosure and abstention in its official records and authorizes the contract in good

faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(i) All claims for money or damages against the health authority shall be governed by Part 3 (commencing with Section 900) and Part 4 (commencing with Section 940) of Division 3.6 of Title 1 of the Government Code, except as provided by other statutes or regulations that expressly apply to the health authority.

(j) The health authority, members of its governing board, and its employees, are protected by the immunities applicable to public entities and public employees governed by Part 1 (commencing with Section 810) and Part 2 (commencing with Section 814) of Division 3.6 of Title 1 of the Government Code, except as provided by other statutes or regulations that apply expressly to the health authority.

(k) Notwithstanding any other provision of law, except as otherwise provided in this section, a county shall not be liable for any act or omission of the health authority.

(*l*) The transfer of responsibility for health care services to the health authority shall not relieve the county of its responsibility for indigent care pursuant to Section 17000.

(m) Notwithstanding any other provision of law, the governing board of the health authority may meet in closed session to consider and take action on matters pertaining to contracts, and to contract negotiations by health authority staff with providers of health care services concerning all matters related to rates of payment.

(n) Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of, and Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of, the Government Code, or any other provision of law, any peer review body, as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the health authority authorized by this section, may, at its discretion and without notice to the public, meet in closed session, so long as the purpose of the meeting is the peer review body's discharge of its responsibility to evaluate and improve the quality of care rendered by health facilities and health practitioners, pursuant to the powers granted to the health authority. Any such peer review body and its members shall receive, to the fullest extent, all immunities, privileges, and protections available to those peer review bodies, their individual members, and persons or entities assisting in the peer review process, including those afforded by Section 1157 of the Evidence Code and Section 1370 of the Health and Safety Code.

(o) Notwithstanding any other provision of law, those records of the health authority and of the county that reveal the health authority's rates of payment for health care services or the health authority's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care

services for rates of payment, shall not be required to be disclosed pursuant to the California Public Records Act, Chapter 5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, or any similar local law requiring the disclosure of public records. However, three years after a contract or amendment to a contract is fully executed, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(p) Notwithstanding the California Public Records Act, or Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of, and Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of, the Government Code, or any other provision of state or local law requiring disclosure of public records, those records of a peer review body, as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the health authority authorized by this section, shall not be required to be disclosed. The records and proceedings of any such peer review body and its individual members shall receive, to the fullest extent, all immunities, privileges, and protections available to those records and proceedings, including those afforded by Section 1157 of the Evidence Code and Section 1370 of the Health and Safety Code.

(q) Except as expressly provided by other provisions of this section, all exemptions and exclusions from disclosure as public records pursuant to the California Public Records Act, including, but not limited to, those pertaining to trade secrets and information withheld in the public interest, shall be fully applicable for all state agencies and local agencies with respect to all writings that the health authority is required to prepare, produce, or submit pursuant to this section.

(r) (1) Any health authority formed pursuant to this section shall obtain licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code).

(2) Notwithstanding subdivisions (b) and (s), a health authority may not operate health plans or programs for individuals covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, or for private businesses, until the health authority is in full compliance with all of the requirements of the Knox-Keene Health Care Service Plan Act of 1975, including tangible net equity requirements applicable to a licensed health care service plan.

(s) Commencing on the date that the health authority first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until the time that the health authority is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed

under the Knox-Keene Health Care Service Plan Act of 1975, the following provisions shall apply:

(1) The health authority may select and design its automated management information system, but the department, in cooperation with the health authority, prior to making capitated payments shall test the system to ensure that the system is capable of producing detailed, accurate, and timely financial information on the financial condition of the health authority and any other information generally required by the department in its contracts with health care service plans.

(2) In addition to the reports required by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, the health authority shall provide on a monthly basis to the department, the Department of Managed Health Care, and the members of the health authority, a copy of the automated report described in paragraph (1) and a projection of assets and liabilities, including those that have been incurred but not reported, with an explanation of material increases or decreases in current or projected assets or liabilities. The explanation of increases and decreases in assets or liabilities shall be provided, upon request, to a hospital, independent physicians' practice association, or community clinic, that has contracted with the health authority to provide health care services.

(3) In addition to the reporting and notification obligations the health authority has under the Knox-Keene Health Care Service Plan Act of 1975, the chief executive officer or director of the health authority shall immediately notify the department, the Department of Managed Health Care, and the members of the governing board of the health authority in writing of any fact or facts that, in the chief executive officer's or director's reasonable and prudent judgment, is likely to result in the health authority being unable to meet its financial obligations to health care providers or to other parties. Written notice shall describe the fact or facts, the anticipated fiscal consequences, and the actions that will be taken to address the anticipated consequences.

(4) The Department of Managed Health Care shall not waive or vary, nor shall the department request the Department of Managed Health Care to waive or vary, the tangible net equity requirements for a health authority under the Knox-Keene Health Care Service Plan Act of 1975 after three years from the date of commencement of capitated payments to the health authority. Until the time the health authority is in compliance with all of the tangible net equity requirements under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, the health authority shall develop a stop-loss program appropriate to the risks of the health

authority. The program shall be satisfactory to both the department and the Department of Managed Health Care.

(5) In the event that the health authority votes to file a petition of bankruptcy, or the board of supervisors notifies the department of its intent to terminate the health authority, the department shall immediately convert the authority's Medi-Cal beneficiaries to either of the following:

(A) To other managed care contractors when available, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees.

(B) To the extent that other managed care contractors are unavailable or the department determines that the action is otherwise in the best interest of any particular beneficiary, to a fee-for-service reimbursement system pending the availability of managed care contractors, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees, or if the department determines that providing care to any particular beneficiary pursuant to a fee-for-service reimbursement system is no longer necessary to protect the continuity of care or other interests of the beneficiary. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted to a fee-for-service reimbursement system or managed care contractor may make a choice to be enrolled in another managed care system, if one is available, in full compliance with the federal freedom-of-choice requirements.

(6) The health authority shall submit to a review of financial records when the department determines, based on data reported by the health authority or otherwise, that the health authority will not be able to meet its financial obligations to health care providers contracting with the health authority. Where the review of financial records determines that the health authority will not be able to meet its financial obligations to contracting health care providers for the provision of health care services, the director shall immediately terminate the contract between the health authority and the state, and immediately convert the health authority Medi-Cal beneficiaries in accordance with paragraph (5) in order to ensure uninterrupted provision of health care services to the beneficiaries and to minimize financial disruption to providers. The action of the director shall be the final administrative determination. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted under paragraph (5) may make a choice to be enrolled in another managed care plan, if one is available, in full compliance with federal freedom-of-choice requirements.

(7) It is the intent of the Legislature that the department shall implement Medi-Cal capitated enrollments in a manner that ensures that appropriate levels of health care services will be provided to Medi-Cal beneficiaries and that appropriate levels of administrative services will be furnished to health care providers. The contract between the department and the health authority shall authorize and permit the department to administer the number of covered Medi-Cal enrollments in such a manner that the health authority's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(8) In the event a health authority is terminated, files for bankruptcy, or otherwise no longer functions for the purpose for which it was established, the county shall, with respect to compensation for provision of health care services to beneficiaries, occupy no greater or lesser status than any other health care provider in the disbursement of assets of the health authority.

(9) Nothing in this subdivision shall be construed to impair or diminish the authority of the Director of the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in the section be construed to reduce or otherwise limit the obligation of a health authority licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the health commissioner of Corporations promulgated thereunder.

(t) In the event a health authority may no longer function for the purposes for which it is established, at the time the health authority's then-existing obligations have been satisfied or the health authority's assets have been exhausted, the board of supervisors may, by ordinance, terminate the health authority.

(u) (1) Prior to the termination of the health authority, the board of supervisors shall notify the department of its intent to terminate the health authority. The department shall conduct an audit of the health authority's records within 30 days of the notification to determine the liabilities and assets of the health authority.

(2) The department shall report its findings to the board within 10 days of completion of the audit. The board shall prepare a plan to liquidate or otherwise dispose of the assets of the health authority and to pay the liabilities of the health authority to the extent of the health authority's assets, and present the plan to the department within 30 days upon receipt of these findings.

(v) Any assets of the health authority shall be disposed of pursuant to provisions contained in the contract entered into between the state and the health authority pursuant to this section.

(w) Upon termination of a health authority by the board, the county shall manage any remaining assets of the health authority until superseded by a department-approved plan. Any liabilities of

the health authority shall not become obligations of the county upon either the termination of the health authority or the liquidation or disposition of the health authority's remaining assets.

SEC. 85. Section 14087.4 of the Welfare and Institutions Code is amended to read:

14087.4. (a) Any contract made pursuant to this article may be renewed if the provider continues to meet the requirements of this chapter, regulations promulgated pursuant thereto, and the contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. The department may condition renewal on timely completion of a mutually agreed upon plan of correction of any deficiencies.

(b) The department may terminate or decline to renew a contract, in whole or in part, when the director determines that such action is necessary to protect the health of the beneficiaries or the funds appropriated to carry out the Medi-Cal program. Nonrenewal or termination under this article shall not qualify the applicant for an administrative hearing including a hearing pursuant to Section 14123.

(c) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this article is necessary. Therefore contracts under this article shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(d) For any contract entered into pursuant to this article, the Director of the Department of Managed Health Care shall, at the director's request and with all due haste, grant an exemption from the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying out the contract.

SEC. 86. Section 14087.9705 of the Welfare and Institutions Code is amended to read:

14087.9705. (a) The commission shall obtain licensure as a health care service plan under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code.

(b) Commencing on the date that the commission first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and the commission is in full compliance with all of the requirements regarding tangible net equity applicable to a health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, all of the following provisions shall apply:

(1) The commission is authorized to select and design its automated management information system, subject to the requirement that the department, in cooperation with the commission, prior to making capitated payments, approve the system. The department shall test the system to ensure that the system is capable of producing detailed, accurate, and timely

financial information on the financial condition of the commission, and any other information that is generally required by the department in its contracts with other local initiatives and with health care service plans.

(2) In addition to the reports required by the Department of Managed Health Care under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code and the rules of the Director of the Department of Managed Health Care adopted and promulgated thereunder, the commission shall provide, on a monthly basis, to the department, the Department of Managed Health Care, and the members of the commission a copy of the automated report described in subdivision (a) and a projection of assets and liabilities, including those that have been incurred but not reported, with an explanation of material increases or decreases in current or projected assets and liabilities. The explanation of increases and decreases in assets or liabilities shall be provided, upon request, to a hospital, independent physicians' practice association, or community clinic that has contracted with the commission to provide health care services.

(3) In addition to the reporting and notification requirements to which the commission is subject under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, the chief executive officer or director of the commission shall immediately notify the department, the Department of Managed Health Care, and the members of the commission, in writing, of any fact or facts that, in the chief executive officer's or director's reasonable and prudent judgment, is likely to result in the commission being unable to meet its financial obligations. The written notice shall describe the fact or facts, the anticipated financial consequences, and the actions that will be taken to address the anticipated consequences.

(4) In no event shall the Department of Managed Health Care waive or vary, nor shall the department request the Department of Managed Health Care to waive or vary, the tangible net equity requirements for a commission under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code after three years after the date of the commencement of capitated payments to the commission. Until the commission is in compliance with all of the tangible net equity requirements under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code and the rules of the Director of the Department of Managed Health Care adopted and promulgated thereunder, the commission shall develop a stop-loss program that is appropriate to the risks of the commission. The stop-loss program shall be subject to the approval of the department and the Department of Managed Health Care.

(5) In the event the commission votes to file a petition of bankruptcy, or the board of supervisors notifies the department that it intends to terminate the commission, the department shall immediately transfer the commission's Medi-Cal beneficiaries to other managed care contractors, when the contractors are available, and the contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees. To the extent that other managed care providers are unavailable or the department determines that the transfer to the other contractors to a fee-for-service reimbursement system is in the best interest of any particular beneficiary, the department shall make that transfer to the fee-for-service system, pending the availability of managed care contractors that can demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees, or until the department determines that providing care to any particular beneficiary pursuant to a fee-for-service reimbursement system is no longer necessary to protect the continuity of care or other interests of the beneficiary. Beneficiaries who have been or who are scheduled to be transferred to a fee-for-service reimbursement system or managed care contractor may make a choice to be enrolled in another managed care system, if one is available, in full compliance with federal freedom-of-choice requirements.

(6) The commission shall submit to a review of financial records when the department determines, based on data reported by the commission or other data received by the department, that the commission will not be able to meet its financial obligations to health care providers contracting with the commission. If the department, pursuant to a review of financial records under this paragraph, determines that the commission will not be able to meet its financial obligation to contracting health care providers for the provision of health care services, the Director of Health Services shall immediately terminate the contract between the commission and the department and shall immediately transfer the commission's Medi-Cal beneficiaries in accordance with paragraph (5) in order to ensure uninterrupted provision of health care services to beneficiaries and to minimize financial disruption. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be transferred under paragraph (5) may make a choice to be enrolled in another managed care plan, if one is available, in full compliance with federal freedom-of-choice requirements.

(7) It is the intent of the Legislature that the department shall implement Medi-Cal capitated enrollments in a manner that ensures that appropriate levels of health care services will be provided to Medi-Cal beneficiaries and that appropriate levels of administrative

services will be furnished to health care providers. The contract between the department and the commission shall authorize the department to administer the number of covered Medi-Cal enrollments in a manner that ensures that the commission's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(8) In the event a commission is terminated, files for bankruptcy, or otherwise no longer functions for the purposes for which it was established, the county shall, with respect to compensation for provision of health care services to beneficiaries, occupy no greater or lesser status than any other health care provider in the disbursement of assets of the commission.

(9) Nothing in this section shall be construed to impair or diminish the authority of the Director of the Department of Managed Health Care under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, nor shall any thing in this section be construed to reduce or otherwise limit the obligation of a commission licensed as a health care plan under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code to comply with the requirements of that chapter, and the rules of the Director of the Department of Managed Health Care adopted thereunder.

SEC. 87. Section 14088.19 of the Welfare and Institutions Code is amended to read:

14088.19. (a) The department may enter into primary care case management contracts pursuant to this article with any health care service plan that is licensed by the Director of the Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

The terms of the contracts entered into pursuant to this section shall be exempt from those provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that regulate health care service plan contracts. Nothing in this section shall preclude the Director of the Department of Managed Health Care from otherwise regulating a health care service plan subject to the Knox-Keene Health Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(b) When a health care service plan enters into a contract pursuant to this article and also pursuant to Chapter 8 (commencing with Section 14200), there shall be no duplication of service areas between the two contracts without prior written approval by the department.

SEC. 88. Section 14089 of the Welfare and Institutions Code is amended to read:

14089. (a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in clearly defined geographical areas. It is, further, the purpose of this article to create maximum accessibility to health care services by permitting Medi-Cal recipients the option of choosing from among two or more managed health care plans or fee-for-service managed case arrangements, including, but not limited to, health maintenance organizations, prepaid health plans, primary care case management plans. Independent practice associations, health insurance carriers, private foundations, and university medical centers systems, not-for-profit clinics, and other primary care providers, may be offered as choices to Medi-Cal recipients under this article if they are organized and operated as managed care plans, for the provision of preventive managed health care plan services.

(b) The negotiator may seek proposals and then shall contract based on relative costs, extent of coverage offered, quality of health services to be provided, financial stability of the health care plan or carrier, recipient access to services, cost-containment strategies, peer and community participation in quality control, emphasis on preventive and managed health care services and the ability of the health plan to meet all requirements for both of the following:

(1) Certification, where legally required, by the Director of the Department of Managed Health Care and the Insurance Commissioner.

(2) Compliance with all of the following:

(A) The health plan shall satisfy all applicable state and federal legal requirements for participation as a Medi-Cal managed care contractor.

(B) The health plan shall meet any standards established by the department for the implementation of this article.

(C) The health plan receives the approval of the department to participate in the pilot project under this article.

(c) (1) (A) The proposals shall be for the provision of preventive and managed health care services to specified eligible populations on a capitated, prepaid or postpayment basis.

(B) Enrollment in a Medi-Cal managed health care plan under this article shall be voluntary for beneficiaries eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(2) The cost of each program established under this section shall not exceed the total amount which the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.

(d) The department shall enter into contracts pursuant to this article, and shall be bound by the rates, terms, and conditions negotiated by the negotiator.

(e) (1) An eligible beneficiary shall be entitled to enroll in any health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides. Enrollment shall be for a minimum of six months. Contracts entered into pursuant to this article shall be for at least one but no more than three years. The director shall make available to recipients information summarizing the benefits and limitations of each health care plan available pursuant to this section in the geographic area in which the recipient resides.

(2) No later than 30 days following the date a Medi-Cal or AFDC recipient is informed of the health care options described in paragraph (1) of subdivision (e), the recipient shall indicate his or her choice in writing of one of the available health care plans and his or her choice of primary care provider or clinic contracting with the selected health care plan.

(3) The health care options information described in paragraph (1) of subdivision (e) shall include the following elements:

(A) Each beneficiary or eligible applicant shall be provided with the name, address, telephone number, and specialty, if any, of each primary care provider, and each clinic participating in each health care plan. This information shall be presented under geographic area designations in alphabetical order by the name of the primary care provider and clinic. The name, address, and telephone number of each specialist participating in each health care plan shall be made available by contacting the health care options contractor or the health care plan.

(B) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the health plans available and has the available capacity and agrees to continue to treat that beneficiary or eligible applicant.

(C) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a health care plan.

(4) At the time the beneficiary or eligible applicant selects a health care plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected health care plan.

(5) Commencing with the implementation of a geographic managed care project in a designated county, a Medi-Cal or AFDC beneficiary who does not make a choice of health care plans in accordance with paragraph (2), shall be assigned to and enrolled in

an appropriate health care plan providing service within the area in which the beneficiary resides.

(6) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the health care plan selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(7) Any Medi-Cal or AFDC beneficiary dissatisfied with the primary care provider or health care plan shall be allowed to select or be assigned to another primary care provider within the same health care plan. In addition, the beneficiary shall be allowed to select or be assigned to another health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.

(8) The department or its contractor shall notify a health care plan when it has been selected by or assigned to a beneficiary. The health care plan that has been selected or assigned by a beneficiary shall notify the primary care provider that has been selected or assigned. The health care plan shall also notify the beneficiary of the health care plan and primary care provider selected or assigned.

(9) This section shall be implemented in a manner consistent with any federal waiver that is required to be obtained by the department to implement this section.

(f) A participating county may include within the plan or plans providing coverage pursuant to this section, employees of county government, and others who reside in the geographic area and who depend upon county funds for all or part of their health care costs.

(g) The negotiator and the department shall establish pilot projects to test the cost-effectiveness of delivering benefits as defined in subdivisions (a) to (f), inclusive.

(h) The California Medical Assistance Commission shall evaluate the cost-effectiveness of these pilot projects after one year of implementation. Pursuant to this evaluation the commission may either terminate or retain the existing pilot projects.

(i) Funds may be provided to prospective contractors to assist in the design, development, and installation of appropriate programs. The award of these funds shall be based on criteria established by the department.

(j) In implementing this article, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this subdivision may be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

SEC. 89. Section 14089.4 of the Welfare and Institutions Code is amended to read:

14089.4. The negotiator may consult with the Department of Insurance or the Department of Managed Health Care and shall consult with the Department of Justice Medi-Cal Fraud Unit, the appropriate licensing boards and the laboratory field services unit of the department for the purposes of determining the qualifications, performance capability, and financial stability of prospective contractors.

SEC. 90. Section 14139.13 of the Welfare and Institutions Code is amended to read:

14139.13. (a) Any contract entered into pursuant to this article may be renewed if the long-term care services agency continues to meet the requirements of this article and the contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. The department may condition renewal on timely completion of a mutually agreed upon plan of corrections of any deficiencies.

(b) The department may terminate or decline to renew a contract in whole or in part when the director determines that the action is necessary to protect the health of the beneficiaries or the funds appropriated to the Medi-Cal program. The administrative hearing requirements of Section 14123 do not apply to the nonrenewal or termination of a contract under this article.

(c) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this article is necessary. Therefore, contracts under this article shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(d) The Director of the Department of Managed Health Care shall, at the director's request, immediately grant an exemption from Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying out any contract entered into pursuant to this article.

SEC. 91. Section 14251 of the Welfare and Institutions Code is amended to read:

14251. ''Prepaid health plan'' means any plan which meets all of the following criteria:

(a) Licensed as a health care service plan by the Director of the Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340), Division 2, Health and Safety Code), other than a plan organized and operating pursuant to Section 10810 of the Corporations Code which substantially indemnifies subscribers or enrollees for the cost of provided services, or has an application for licensure pending and was registered under the Knox-Mills Health Plan Act prior to its repeal (Chapter 941, Statutes of 1975) or licensed

as a nonprofit hospital service plan by the Insurance Commissioner pursuant to Section 11493(e) and Sections 11501 to 11505 of the Insurance Code.

(b) Meets the requirements for participation in the Medicaid Program (Title XIX of the Social Security Act) on an at risk basis.

(c) Agrees with the State Department of Health Services to furnish directly or indirectly health services to Medi-Cal beneficiaries on a predetermined periodic rate basis.

''Prepaid health plan'' includes any organization which is licensed as a plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 and is subject to regulation by the Department of Managed Health Care pursuant to that act, and which contracts with the State Department of Health Services solely as a fiscal intermediary at risk.

Except for the requirement of licensure pursuant to the Knox-Keene Act, the State Director of Health Services may waive any provision of this chapter which the director determines is inappropriate for a fiscal intermediary at risk. Any such exemption or waiver shall be set forth in the fiscal intermediary at risk contract with the State Department of Health Services.

''Fiscal intermediary at risk'' means any entity which entered into a contract with the State Department of Health Services on a pilot basis pursuant to subdivision (f) of Section 14000, as in effect June 1, 1973, in accordance with which the entity received capitated payments from the state and reimbursed providers of health care services on a fee-for-service or other basis for at least the basic scope of health care services, as defined in Section 14256, provided to all beneficiaries covered by the contract residing within a specified geographic region of the state. The fiscal intermediary at risk shall be at risk for the cost of administration and utilization of services or the cost of services, or both, for at least the basic scope of health care services, as defined in Section 14256, provided to all beneficiaries covered by the contract residing within a specified geographic region of the state. The fiscal intermediary at risk may share the risk with providers or reinsuring agencies or both. Eligibility of beneficiaries shall be determined by the State Department of Health Services and capitation payments shall be based on the number of beneficiaries so determined.

SEC. 92. Section 14308 of the Welfare and Institutions Code is amended to read:

14308. (a) Each prepaid health plan shall furnish to the director such information and reports as required by Title XIX of the federal Social Security Act.

(b) The director may require a prepaid health plan to provide the director with information and reports which are furnished by the prepaid health plan to the Director of the Department of Managed Health Care pursuant to the provisions of Chapter 2.2 (commencing with Section 1340), Division 2, of the Health and Safety Code, the

Knox-Keene Health Care Service Plan Act of 1975, or to the Insurance Commissioner pursuant to the provisions of Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate.

(c) The director may, by regulation, require plans to furnish statistical information to the extent such information is necessary for the department to establish rates of payment pursuant to Section 14301 and to provide reports pursuant to Section 14313. The department shall, to the extent feasible, accept this information in a form which is consistent with reports required to be provided pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate. In the case of a hospital based plan which is a health maintenance organization qualified pursuant to Title XIII of the federal Public Health Service Act, and which has more than one million enrollees, of whom less than 10 percent are Medi-Cal enrollees, information required pursuant to this subdivision shall consist of reports required to be made to the Department of Health, Education and Welfare pursuant to Title XIII of the federal Public Health Service Act.

SEC. 93. Section 14456 of the Welfare and Institutions Code is amended to read:

14456. The department shall conduct annual medical audits of each prepaid health plan unless the director determines there is good cause for additional reviews.

The reviews shall use the standards and criteria established pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate. Except in those instances where major unanticipated administrative obstacles prevent, or after a determination by the director of good cause, the reviews shall be scheduled and carried out jointly with reviews carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate, if reviews under either act will be carried out within time periods which satisfy the requirements of federal law.

The department shall be authorized to contract with professional organizations or the Department of Managed Health Care or the Department of Insurance, as appropriate, to perform the periodic review required by this section. The department, or its designee, shall make a finding of fact with respect to the ability of the prepaid health plan to provide quality health care services, effectiveness of peer review, and utilization control mechanisms, and the overall performance of the prepaid health plan in providing health care benefits to its enrollees.

SEC. 94. Section 14457 of the Welfare and Institutions Code is amended to read:

14457. In addition to the reviews required or authorized by Section 14456, the department shall conduct periodic onsite visits or additional visits after a determination by the director of good cause by departmental representatives to include observation of the general operation of the prepaid health plan, the condition of the facilities for delivering health care, the availability of emergency services, the degree of satisfaction of the enrollees, the operation of the plan's grievance system, and the administrative and financial aspects of the operation of the prepaid health plan.

Except when reviewing a plan's grievance system or marketing activities, this evaluation shall use standards and criteria established pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate. Except in those instances where major, unanticipated administrative obstacles prevent, or after a determination by the director of good cause, the visits shall be scheduled and carried out jointly with reviews carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate, if reviews under either act will be carried out within time periods which satisfy the requirements of federal law.

The State Department of Health Services may contract with the Department of Managed Health Care or the Department of Insurance, as appropriate, to perform the periodic visits required by this section.

SEC. 95. Section 14459 of the Welfare and Institutions Code is amended to read:

14459. (a) The prepaid health plan shall maintain financial records and shall have an annual audit or additional audits after a determination by the director of good cause, performed by an independent certified public accountant. A prepaid health plan operated by a public entity shall have an annual audit performed in a manner approved by the department. All certified financial statements shall be filed with the department as soon as practical after the end of the prepaid health plan's fiscal year and in any event, within a period not to exceed 90 days thereafter. These financial statements shall be filed with the department and shall be public records. The department shall perform routine auditing of prepaid health plan contractors and their affiliated subcontractors. Except in those instances where major unanticipated obstacles prevent, or after a determination by the director of good cause, the audits shall be scheduled and carried out jointly with audits carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, or to Chapter 11A (commencing with Section 11491) of Part 2 of Division

2 of the Insurance Code, as appropriate, if audits under either act are carried out within time periods which satisfy the requirements of federal law. The department is authorized to contract with the Department of Managed Health Care or the Department of Insurance, as appropriate, to carry out the audits required by this section. The prepaid health plan shall make all of its books and records available for inspection, examination or copying by the department during normal working hours at the prepaid health plan's principal place of business or at such other place in California as the department shall designate. For good cause, the department may grant an exception to the time when annual financial statements are to be submitted to the department. The annual report required in Section 14313 shall include an itemization of expenditures made by each prepaid health plan for the following categories of expenditures: physician services, inpatient and outpatient hospital services, pharmaceutical services and prescription drugs, dental services, medical transportation services, vision care services, mental health services, laboratory services, X-ray services, enrollee education programs, marketing and enrollment costs, data-processing costs, other administrative costs and health service expenditures and any payments made to subcontractors, and the purposes of the payments, including but not limited to, contributions to election campaigns.

(b) The requirements of a financial and administrative review by the department of any health care service plan licensed by the Director of the Department of Managed Health Care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code may be waived upon submission of the financial audit for the same period conducted by the Department of Managed Health Care pursuant to Section 1382 of the Health and Safety Code.

SEC. 96. Section 14460 of the Welfare and Institutions Code is amended to read:

14460. A schedule of reviews, visits, and audits shall be jointly established by the Department of Managed Health Care or the Department of Insurance, as the case may be, and the State Department of Health Services. Nothing in Section 14456, 14457, or 14459 shall be construed to prohibit the State Department of Health Services from conducting reviews, visits, or audits either jointly or individually, for the purpose of following up on findings resulting from reviews, visits, or audits carried out in accordance with this chapter.

SEC. 97. Section 14482 of the Welfare and Institutions Code is amended to read:

14482. No prepaid health plan shall contract with any subcontractor other than the plan's subsidiary corporation, its parent corporation, or another subsidiary of its parent corporation, or an

affiliate of the prepaid health plan whose financial statements are consolidated with that of the prepaid health plan at the time of the annual audit by the independent auditors of the plan and when the quarterly and annual financial statements are filed with the Director of the Department of Managed Health Care, if any of the following persons connected with the plan have a substantial financial interest, as defined by Section 14478, in such subcontractor:

(a) Any person also having a substantial financial interest in the plan.

(b) Any director, officer, partner, trustee, or employee of the plan.

(c) Any member of the immediate family of any person designated in (a) or (b).

SEC. 98. Section 14499.71 of the Welfare and Institutions Code is amended to read:

14499.71. For the purposes of this article, ''fiscal intermediary'' means an entity that agrees to pay for covered services provided to Medi-Cal eligibles in exchange for a premium, subscription charge, or capitation payment; to assume an underwriting risk; and is either licensed by the Director of the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or is licensed as a nonprofit hospital service plan by the Insurance Commissioner pursuant to subdivision (e) of Section 11493 of the Insurance Code and Sections 11501 to 11505, inclusive, of the Insurance Code.

SEC. 99. (a) Any section of any act enacted by the Legislature during the 2000 calendar year that takes effect on or before January 1, 2001, and that amends, amends and renumbers, adds, repeals and adds, or repeals a section that is amended, amended and renumbered, added, repealed and added, or repealed by this act, shall prevail over this act, whether that act is enacted prior to, or subsequent to, the enactment of this act. The repeal, or repeal and addition, of any article, chapter, part, title, or division of any code by this act shall not become operative if any section of any other act that is enacted by the Legislature during the 2000 calendar year and takes effect on or before January 1, 2001, amends, amends and renumbers, adds, repeals and adds, or repeals any section contained in that article, chapter, part, title, or division.

(b) Subdivision (a) shall not apply to the following:

(1) Health and Safety Code Sections 1341.7, 1343, 1363, 1367.25, 1368.2, 1374.30, 1374.32, 1383.15, 1391.5, and 1398.

(2) Insurance Code Sections 742.435, 10169, 10169.2, 10169.3, 10169.5 and 10279.

SEC. 100. (a) The Department of Managed Care shall hereafter be known as the Department of Managed Health Care in all statutes that reference the Department of Managed Care.

(b) The Advisory Committee on Managed Care shall hereafter be known as the Advisory Committee on Managed Health Care in all statutes that reference the Advisory Committee on Managed Care.

(c) The Managed Care Fund shall hereafter be known as the Managed Health Care Fund in all statutes that reference the Managed Care Fund.

O